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Task Force Report: Missouri's Long-term Care Partnership Program

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TABLE OF CONTENTS

Section 1: Executive Summary
Background…… 6
Implications for Missouri…… 6
Recommendations for Strengthening the Missouri Long-term Care Partnership Program Act…… 7
Recommendations for Additional Cost-Saving Options for Missouri…… 8

Section 2: Mapping the Story of This Policy Brief 9

Section 3: What Is Long-term Care and Why Does It Need Insurance?
What Are LTC Services?…… 11
Ways to Finance LTC Services…… 12
What Is Long-term Care Insurance (LTCI)?…… 14
What Are Partnership Programs?…… 16

Section 4: The Ideal Long-term Care System and its Stakeholders
The Ideal Long-term Care System: Equitable and Cost Effective…… 17
Identified Stakeholders…… 18
The Consumers Themselves: Missouri's Older Adults…… 18
Caregivers…… 19
Taxpayers…… 21
Legislators & State Administrators…… 21
Insurance Industry…… 21
Service Providers…… 22

Section 5: Quality of LTCI Partnership Programs
What Services Does a Typical Policy Cover?…… 23
What to Consider When Choosing an LTC Policy?…… 23
Covered Benefits…… 23
Length of Coverage…… 23
Elimination Periods…… 23
Non-forfeiture…… 24
Inflation Protections…… 24
Implications & Recommendations for Missouri…… 24

Section 6: Access to LTCI through Partnership Programs
Who Purchases LTCI Partnership Programs?…… 25
Who is Left Out?…… 27
Implications & Recommendations for Missouri…… 29
A Case Study: Ethel…… 30

Section 7: The Economics of LTCI
Economic Impact of Partnership Programs in California, Connecticut, Indiana & New York…… 32
Costs to the Individual…… 33
Costs to Missouri…… 35
How Equitable Are the Costs to Missourians?…… 36

Increasing Access to LTCI Partnership Programs through Tax Credits…………….. 36

Section 8: How Do We Keep Partnership Programs Accountable?
Insurance Standards & Consumer Protections……………………………………….. 40
Regulation & Oversight……………………………………………………….…..... 40
Implications & Recommendations for Missouri…………………………………... 42

Section 9: Recommendations & Supplemental Options in Light of Current Legislation
Summary of Recommendations & Improvements…………………………………… 44
Feasible Supplemental Options to Consider……………………………………….. 45
Increased Access to Home and Community Based Services (HCBS) Waivers....... 46
Increased Utilization of PACE Model…………………………………………….. 46

Section 10: Conclusion 48

Section 11: Appendix
Appendix A. Comparison of pilot states…………………………………………….. 50
Appendix B. Selected consumer advice on long-term care insurance………………. 51
Appendix C. Comparison of current (2007) legislation establishing the Missouri Long-term Partnership Act………………………………………………………. 53

References 55

TABLE OF TABLES

Table 1. Characteristics of individual long-term care insurance policies purchased in 1990, 1995, and 2000……………………………………………………………………………. 15
Table 2. Long-term care costs: Now and in the future……………………………………… 20
Table 3. Estimated future Medicaid long-term care expenditure…………………………… 21
Table 4. Income and assets at time of purchase (Purchaser surveys conducted by states)…. 26
Table 5. Demographics of partnership plan buyers (at time of purchase)………………….. 27
Table 6. Average annual premiums for top long-term care insurance sellers in 2002……… 28
Table 7. Ethel's case study………………………………………………………………. 30
Table 8. Cost of long-term care insurance partnership program by age (dollar)…………… 33
Table 9. Household incomes and expenses………………………………………………… 34
Table 10. Revenue reduction by LTCI partnership program (dollar)……………………….. 35
Table 11. Long-term care market penetration and probability of lapsing by income in 2025 under tax credits and tax deductions……………………………………………………… 37
Table 12. Tax credit schedule…………………………………………………………….. 39

TABLE OF FIGURES

Figure 1. Medicaid Spending (2005)……………………………………………………... 13
Figure 2. Medicare's Share of Long-Term Care Spending (2005)………………………….. 14
Figure 3. Mary Rose Derks' experience with Conseco, her long-term care insurance provider…………………………………………………………………………………….. 41

Summary of Task Force Findings

As part of a task force formed in Dr. Michelle Putnam's Social Policy and Aging course, students from the Brown School of Social Work at Washington University in St. Louis have been researching long-term care partnership programs and their potential for financing long-term care services in the state of Missouri. The following represents the findings of this task force.

The goal of partnership programs is to encourage individuals to purchase long-term care insurance by sharing the costs of policy premiums with the state. Long-term care insurance partnership programs began in 1987 as a Robert Wood Johnson Foundation-funded demonstration project in an effort to explore options for reducing the financial burden of long-term care on Medicaid. Originally piloted in four states, the first partnership programs provide initial data in their effectiveness in alleviating the states' long-term care financing burden.

- To date, the partnership programs have saved the four states a combined $8-10 million in health care bills.[1]
- Almost one-half of partnership purchasers have assets greater than $350,000, and a significant proportion of buyers have annual income that exceeds $60,000. The exception to this is Connecticut, where an average of 20% of purchasers have less than $100,000 in assets and 57% of purchasers have an annual income of less than $30,000.[2] To date, the partnership programs in the original four states have not attracted the numbers of middle- and lower-income individuals that they had originally envisioned.
- Estimates indicate a 7% reduction in Medicaid spending by 2016-2020[3]. This task force predicts that Missouri would need a minimum of 7,458 people receiving long-term care services through a partnership policy, who would have otherwise received services through Medicaid Insurance, to realize this level of savings.

Our findings suggest Missouri can realize cost-savings in its long-term care spending through the careful implementation of the long-term care partnership program; however, even more cost-savings can be realized through expanding access and usage of existing programs. Regarding the long-term care insurance partnership program, policies must be made affordable and attractive to purchasers in the middle- to lower-income bracket, precisely those who might not otherwise purchase long-term care insurance. This type of targeting can be achieved with the state's help through offering tax deductions and credits, as well as premium assistance and subsidies. However, even with these incentives in place and if proper targeting is successful, savings will take anywhere from 10 to 20 years to be fully realized. Expansion of existing programs within the state's long-term care system will show more immediate financial benefit to the state. Specifically, expanding eligibility for Home and Community Based Waivers (HCBS) and increasing use of Programs for All-Inclusive Care for the Elderly (PACE) have already saved tens of millions of dollars for the state of Missouri.[4]

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[1] Meiners, M. (2006). *Program to promote long-term care insurance for the elderly.* Retrieved April 18, 2007, from Robert Wood Johnson Foundation website**:** http://www.rwjf.org/reports/npreports/elderlye.htm

[2] Stone-Axelrad, J. (2005). *Medicaid's long-term care insurance partnership program.* Congressional Research Service. The Library of Congress.

[3] Meiners, M.

[4] Missouri Medicaid Basics (2006). Retrieved on February 3, 2007 from http://www.mffh.org/policy_medbasics.htm

Section 1: Executive Summary

Background

Long-term care insurance partnership programs began in 1987 as a Robert Wood Johnson Foundation-funded demonstration project. Under this demonstration project four states developed partnership programs: California, Connecticut, New York, and Indiana.[5] It is important to note that these four states actually implemented their programs in the early 1990s and were the only states allowed to pilot the partnership programs.[6] The Deficit Reduction Act of 2005 lifted the moratorium on the remaining states making it possible for other states to consider implementing partnership programs; giving birth to proposed new legislation in over twenty other states and several published papers and articles evaluating how the partnership programs are performing. Some highlights of the resulting evaluations follow:

- To date, the partnership programs have saved the four states a combined $8-10 million in health care bills.[7]
- As of January 2005, approximately 181,600 partnership policies had been purchased across the four states.[8]
- A total of $2.8 million in assets have been protected for persons in California, Connecticut, and Indiana who qualified for Medicaid.[9]
- Almost one-half of partnership purchasers have assets greater than $350,000, and a significant proportion of buyers have annual income that exceeds $60,000. The exception to this is Connecticut, where an average of 20% of purchasers have less than $100,000 in assets and 57% of purchasers have an annual income of less than $30,000.[10] To date, the partnership programs in the original four states have not attracted the numbers of middle- and lower-income individuals that they had originally envisioned.

Implications for Missouri

Missouri's implementation of a long-term care insurance partnership program should take into account the needs of the consumer. A consumer-friendly policy would include: increasing state tax incentives for non-reimbursed premiums, providing comprehensive consumer outreach and education, protecting the consumer against provider financial instability, and offering additional provisions to strengthen the consumer incentives to purchase long-term care insurance. It is important to recognize the potential financial implications to Missouri's budget when implementing a partnership program of this nature, which include:

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[5] Government Accountability Office, *Overview of long-term care partnership programs*. Retrieved March 5, 2007, from http://www.gao.gov/new.items/d051021r.pdf
[6] Ahlstrom, A., Clements, E., Tumlinson, A., & Lambrew, J. *The long-term care partnership program: Issues and options*. George Washington University. Washington, D.C.
[7] Meiners, M.
[8] Stone-Axelrad, J.
[9] Stone-Axelrad, J.
[10] Stone-Axelrad, J.

- The estimated cost to the General Revenue Fund will be approximately $2,880,000 in fiscal year 2008, fiscal year 2009, and fiscal year 2010.[11]
- Estimates indicate a 7% reduction in Medicaid spending by 2016-2020.[12] This task force predicts that Missouri would need a minimum of 7,458 people receiving services through a partnership policy, who would have otherwise received services through Medicaid Insurance, to realize this level of savings.
- It will take several years for Missouri to realize any savings to Medicaid from a partnership program. To realize this anticipated savings, Missouri will need to effectively target those most at-risk for spending down their assets to qualify for Medicaid Insurance. Those most at-risk are defined as middle- to lower-income individuals with minimal assets.

Recommendations for Strengthening the Missouri Long-term Care Partnership Program Act

The task force recommends implementation of the partnership program because some consumers stand to benefit from its establishment. Given that the state's Department of Insurance must certify that the long-term care insurance policy has met certain standards, the purchaser can be assured that qualified policies contain standard provisions established to protect the consumer. Also, receiving long-term care through a private insurance policy provides additional assurance that the policyholder can access long-term care services in the least restrictive environment. Privately-paid long-term care gives the consumer greater control over the care he/she will receive. Greater access to long-term care insurance, therefore, has the ability to empower more of Missouri's citizens to direct their long-term care services.

The task force has determined that Missouri can realize cost-savings from implementing the long-term care insurance partnership program, but this can only be accomplished with appropriate targeting of purchasers. Policies must be made affordable and attractive to purchasers in the middle- to lower-income bracket, precisely those who might not otherwise purchase long-term care insurance. This type of targeting can be achieved with the state's help through offering tax deductions and credits, premium assistance, and subsidies. Even with these incentives in place and if proper targeting is successful, savings will take anywhere from 10 to 20 years to emerge. To help with targeting, the task force recommends that the state of Missouri provide incentives for purchasing long-term care insurance policies by exploring the following options:

- Offering a tax credit in addition to the tax deduction; the tax credit would provide a greater benefit to those with lower incomes.[13]
- Providing deductions through cafeteria plans and flexible spending accounts through employers;
- Allowing premium payments without penalty from IRA, 401(k), and similar tax-deferred retirement accounts;

[11] Fiscal Note, Missouri HB 40 House Perfected Version.
[12] Meiners, M.
[13] CFD (2007). Retrieved on April 1, 2007 from http://www.cfed.org

- Subsidizing the purchase of long-term care insurance policies through offering means-tested individuals premium assistance through subsidies paid directly to the provider.

Additionally, the task force thinks it is essential to offer consumers comprehensive education about long-term care services and guidance through the purchasing process, in order to assist consumers in making informed decisions about the services they need covered and the various consumer protections that are available to them.

Recommendations for Additional Cost-Saving Options for Missouri

While this task force estimates that Missouri can achieve cost-saving in their long-term care spending through the careful implementation of the Missouri Partnership for Long-term Care, there are programs in existence that are already saving money for the state of Missouri and could potentially save significantly more money for the state with the expansion of their access and use.

The Home and Community Based Services (HCBS) waivers have saved Missouri over $300 million in Medicaid services based on nursing home diversion, or the provision of services in the home and community to those who otherwise would have been placed in a nursing home.[14] As a supplement to the partnership program, HCBS waivers offer a cost-effective method for those who cannot access long-term care insurance policies (such as those with pre-existing conditions or disabilities) to receive equal access to long-term care services in the least restrictive environment. Another program already in place is the Programs for All-Inclusive Care for the Elderly (PACE). This program has also saved Missouri between $40 to 80 million in Medicaid spending.[15] Increased utilization of the PACE model, as well as increased access and use of HCBS waivers, would result in more immediate cost-savings to Missouri's long-term care spending than the partnership program can currently provide.

[14] Frakt, A. & Pizer, S. (2001). Tax incentives for long-term care insurance: A microsimulation analysis. Abt Associates, Inc.: Cambridge, MA.
[15] Frakt, A. & Pizer, S.

Section 2: Mapping the Story of this Policy Brief

Dr. Michelle Putnam's Social Policy and Aging class at the Brown School has developed policy briefs over the past two years regarding the current Medicaid system in Missouri. This has become a valuable assignment not only for the class; but also to the Missouri State Legislature, governmental agencies, commissions, boards, and non-profit agencies. This year two subjects that are of great concern to Missourians are addressed: long-term care insurance partnership programs and caregiver support programs. This Long-term Care Insurance Task Force has been formed to review and make recommendations based upon Missouri efforts to implement a long-term care insurance partnership program. The current MO HealthNet proposal contains a recommendation that Missouri develop a long-term care insurance partnership program to encourage citizens to finance long-term care by purchasing insurance.

> ***"Seniors also can be vulnerable, and we have a moral obligation to them. They raised and instructed us, so it is up to us to pay them back for their love and sacrifice."*** -Governor Matt Blunt

Governor Blunt signaled his support for this recommendation in the 2007 State of the State Address as he stated, "Seniors also can be vulnerable, and we have a moral obligation to them. They raised and instructed us, so it is up to us to pay them back for their love and sacrifice." He then called for support of a 100% tax deduction on premiums paid toward long-term care insurance.[16] The 2007 Legislative body has also showed their interest by sponsoring bills to establish a Long-term care insurance public-private partnership program.

The ongoing debate over the high cost of Medicaid (specifically the financial drain of long-term care on Medicaid) and the continued efforts to reform Medicaid in Missouri underscores the timeliness of this report. Specifically, this Task Force Report will address the following questions:

a) **Would a long-term care insurance program reduce Missouri's expenditures on long-term care in the Medicaid Program?**

b) **Are there other equal or more feasible options Missouri should consider implementing?**

The legislation currently under consideration in Missouri has support from a bi-partisan contingent and the long-term care provider community. The Task Force recognizes the fact that Long-term care insurance (LTCI) and public-private partnerships (partnership programs) are not entirely new developments; as they were previously implemented in four states: California, Connecticut, Indiana, and New York, prior to the federal government placing a moratorium on the development of new partnership programs through the Omnibus Budget Reconciliation Act of 1993. Missouri is now positioned to pursue partnership programs through the Deficit Reduction Act of 2005 (DRA 2005) signed by President Bush in 2006, which effectively allows all fifty states to once again establish long-term care insurance partnership programs.[17]

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[16] Blunt, M. (January 25, 2007). State of the State Address. Retrieved on February 3, 2007, from http://www.gov.mo.gov/State_of_the_State_2007.htm

[17] Meiners, M.

This is an exciting development for Missouri; however, before moving forward it is imperative for legislators to have a well-informed understanding of the issues. For the partnership program this includes:

- Awareness of the growing older adult population in Missouri,
- Knowledge of current Medicaid insurance spending on long-term care,
- An understanding of who will benefit from the partnership program,
- And identification of who will not benefit.

This Task Force Report reviews the partnership programs implemented prior to 1993, evaluates the current state of long-term care financing in Missouri, and makes recommendations towards implementation of partnership programs in Missouri, as well as suggesting other equally feasible policies that will strengthen the financing of long-term care in Missouri.

Section 3: What Is Long-term Care and Why Does It Need Insurance?

What are Long-term Care Services?

Currently 14 million people report possessing some functional limitation that impedes their completion of at least some of the daily tasks of living. Of these, six million people receive long-term care services.[18] Long-term care has received extensive media and political coverage, particularly as policymakers direct their attention to the expense of providing long-term care services to the growing older adult population. Long-term care as a concept is often juxtaposed with acute-care, and the boundary between the two classifications is somewhat ill-defined.[19] It is an important distinction to make; however, due to the fact that for the most part Medicare covers the costs for acute services, while Medicaid generally covers a significant proportion of the cost of long-term care services.

Long-term care is defined as "an array of institutional-, home-, and community-based services, including nursing homes, respite care, adult day care, hospice services, case management, transportation and housing assistance, homemaker and chore services, and personal companions."[20] Assistance may be required for many of the activities or needs of daily living and may include help with the following:

- Walking
- Bathing
- Using the bathroom
- Incontinence
- Pain management
- Preventing unsafe behavior
- Physical or occupational therapy
- Attending to medical needs
- Providing meals
- Providing transportation
- Administering medications
- Attending to personal hygiene

At least 60% of all individuals will need extended help in one or more of the areas above during their lifetime.[24]

The need for long-term care may last for weeks, months, or years; depending on the underlying reasons for requiring care, which may be the result of a terminal condition, disability, illness, injury, or age-related health issue.[21] Long-term care services can be administered by family members, friends, or paid caregivers.[22] Social and environmental need factors into the design of long-term care systems, thus distinguishing long-term care from acute care in that the former

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[18] Alliance for Health Reform. (2006). *Covering Health Issues 2006-2007*, (p.93). Retrieved on February 3, 2007 from http://www.allhealth.org/sourcebook2006/toc.asp

[19] Stone, R. (2000). Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century. Milbank Memorial Fund. New York, NY.

[20] Torres-Gil, F. & Putnam, M. (2004). The politics of aging with a disability: Health care policy and the shaping of a public agenda. In Kemp, B. & Mosqueda. (2004). *Aging with a disability: A clinician's guide.* (268). Baltimore, MD: Johns Hopkins Press.

[21] Day, T. (n.d.). Long term care insurance. Retrieved on April 1, 2007, from www.longtermcarelink.net/a9insurance.htm

[22] Cohen, M. (2003). Private long-term care insurance: A look ahead. *Journal of Aging Health, 15*. (pp. 74-98).

requires a broader perspective than the latter, which is dominated by the medical model.[23] It is estimated that at least 60% of all individuals will need extended help in one or more of the areas above during their lifetime.[24]

Ways to Finance Long-term Care Services

There are three main vehicles for financing long-term care services: informal, public, and private funding sources. The expense of long-term care surpasses the ability of most families to pay for it out-of-pocket, thereby making both informal care and third-party payments extremely important.[25] Individuals currently spend billions of dollars out-of-pocket on long-term care costs; while private long-term care insurance provides for a relatively small proportion of these expenditures.[26] A majority of older persons (approximately 65%) rely exclusively on informal caregivers due to the lack of long-term care coverage provided by Medicaid and Medicare and the high cost of services.[27] In Missouri, an estimated 600,000 caregivers provide 613 million hours of informal care, which is equivalent to over $6 billion. In fact, national statistics estimate the value of informal caregiving to be in excess of $300 billion.[28] Long-term care financing clearly receives a significant subsidy in the form of informal provision of care.

Medicaid currently bears the brunt of long-term care expenditures and, absent significant policy change, is expected to continue to be the major source of funding for long-term care in the future.[29] In 2004, $194 billion was spent on long-term care in the United States, 49% of which was financed by Medicaid.[30] In 2005, long-term care spending accounted for 31% of Medicaid spending nationally.[31]

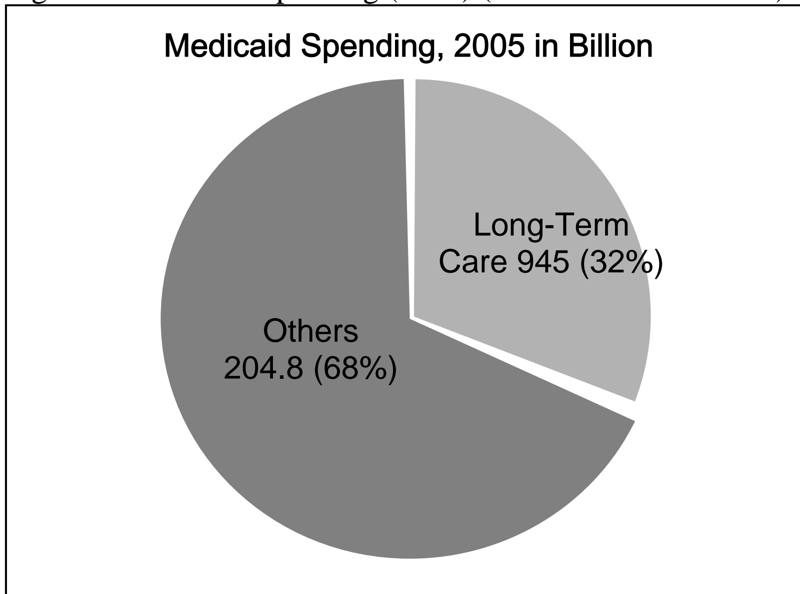
…the single largest out-of-pocket expense for Medicare beneficiaries is for long-term care.[34]

In 2005, Missouri expenditures on long-term care equaled an estimated 25% of the state's total Medicaid spending, ranking Missouri 43rd among 50 states in long-term care Medicaid expenditures.[32] Although it is commonly believed that Medicare funds long-term care; in fact, Medicare does not pay for long-term care, but rather covers services related to acute illnesses with

[23] Stone, R. (2000). Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century. Milbank Memorial Fund. New York, NY.
[24] Cohen, M.
[25] Alliance for Health Reform. (2006). *Covering Health Issues 2006-2007*. Retrieved on February 3, 2007 from http://www.allhealth.org/sourcebook2006/toc.asp
[26] Stone, R.
[27] U.S. Administration on Aging. (2000, Fall). *America's families care: A report on the needs of America's family caregivers*. Retrieved (March 26, 2003) from http://www.aoa.gov/carenetwork/report.html
[28] State of the States in Family Caregiver Support. (n.d.). Retrieved January 25, 2007, from http://www.caregiver.org/caregive/jsp/content_node.jsp?nodeid=1185, Family Caregiver Alliance.
[29] O'Brien, E. (2005). Long-term care: Understanding Medicaid's role for the elderly and disabled. In *The Kaiser Commission on Medicaid and the uninsured*. Retrieved on February 5, 2007, from http://www.allhealth.org/briefingmaterials/Kaiser-LTC_MedicaidsroleforElderlyandDisabled-633.pdf.
[30] Komisar, H. & Thompson, L. (2007). Fact sheet. *National spending for long-term care*. Washington, D.C.: Georgetown University Long-Term Care Financing Project.
[31] Houser, A., Fox-Grage, W., & Gibson, M. (2006). *Across the states: Profiles of long-term care and independent living*, (7th ed). AARP Public Policy Institute.
[32] Houser, A., Fox-Grage, W., & Gibson, M.

relatively short durations. Medicare will pay for institutional and home-based care, but only for a short period of time.[33] At the same time, nearly one-third of the population covered by Medicare insurance experiences difficulties performing activities of daily living.[34] Given that Medicare does not provide full coverage of services to help with long-term care needs, individuals must bear the burden of this expense. In conclusion, the single largest out-of-pocket expense for Medicare beneficiaries is for long-term care.[35]

Figure 1: Medicaid Spending (2005) (*Total = $300.3 billion*)



Source: Health Policy Institute, Georgetown University, based on data from B. Burwell, S. Eiken, and K. Sredl, "Medicaid long-term care expenditures in FY2005" (Cambridge, MA: Medstat, July 5, 2006, memorandum).

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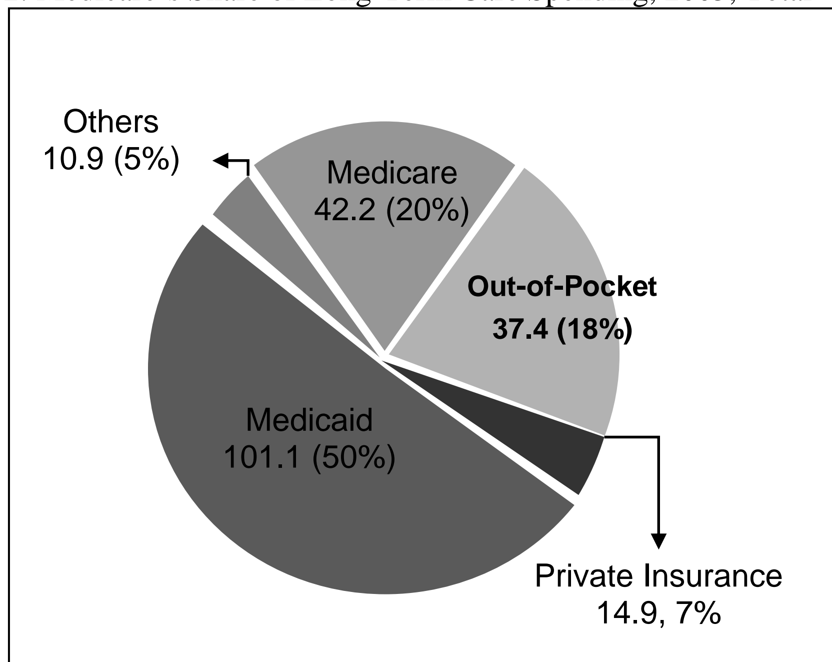
33 Health Policy Institute. (2007). Medicare and long-term care financing. Washington, D.C.: Georgetown University Long-Term Care Financing Project.

34 Health Policy Institute. (2007).

35 In 1999, spending on long-term care accounted for 41% of direct out-of-pocket spending, spending on prescription drugs for 21%. Medicare cost sharing accounted for 27%. See CMS, Program Information on Medicare, Medicaid, and SCHIP, June 2002 edition, Section III.B.5, p. 8. http://www.cms.hhs.gov/TheChartSeries/downloads/sec3b_p.pdf**.**

Figure 2: Medicare's Share of Long-Term Care Spending, 2005, Total = $206.6 billion



Source: H. Komisar and L. Thompson, National Spending of Long-Term Care (Washington, DC: Georgetown University Long-term Care Financing Project, February 2007, fact sheet)

The final mechanism for financing long-term care for older adults is through the private market. Private sources include private long-term care insurance benefits, income derived from private retirement accounts, and other privately held wealth and assets. Figure 2 illustrates that out-of-pocket payments accounted for 37.4% of long-term care spending in 2005, while private insurance policies covered only 14.9% of long-term care spending.[36]

Given the reliance upon Medicaid as the primary financer of long-term care services (the value of informal care notwithstanding) many states are looking to the cost-sharing solution of long-term care insurance partnership programs to help alleviate this financial burden.

What Is Long-term Care Insurance (LTCI)?

Long-term care insurance policies are currently available primarily through the private insurance market, similar to how an individual consumer might access automobile or health insurance. However, unlike health insurance, most employers do not share the cost of their workers' long-term care insurance, or in many cases even offer long-term care insurance[37] There has been significant growth of employer-group policies (policies in which the cost for long-term care insurance is shared between employee and employer) over the past decade and a half, with employer-group sales almost doubling between 1995 and 1999.[38]

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[36] Komisar, H. & Thompson, L.
[37] Alliance for Health Reform. (2006). *Covering Health Issues 2006-2007.* Retrieved on February 3, 2007 from http://www.allhealth.org/sourcebook2006/toc.asp
[38] Cohen, M.(2003). Private Long-Term Care Insurance. *Journal of Aging and Health, 15(1),* 74-98.

Private policies can offer a variety of possible benefits. In the early 1990s, benefit packages typically covered only institutional care; however, the current trend is for policy benefits to cover both home and community-based services.[39] Table 1 displays the evolution of policy characteristics through 2000. The data demonstrates that coverage for consumers to access care in a variety of care settings has grown significantly; highlighting one of the strengths of private long-term care insurance—maximization of consumer choice.

Table 1. Characteristics of individual long-term care insurance policies purchased in 1990, 1995, and 2000

Policy Characteristic	Average for 1990	Average for 1995	Average for 2000
Covers nursing home only	63%	33%	14%
Covers nursing home & home care	37%	61%	77%
Covers home care only	———	6%	9%
Daily benefit for nursing home care	$72	$85	$109
Daily benefit for home care	$36	$78	$106
Nursing home benefit duration	5.6 years	5.1 years	5.5 years
Annual premium	$1,071	$1,505	$1,677

Source: Based on LifePlans, Inc. analysis of 5,407 policies sold in 2000, 6,446 policies sold in 1995 and 14,400 policies in 1990. Contained in HIAA (1992, 1995, 2000). Note: Premiums are in constant dollars and reflect changes in policy design configurations over time.

Benefits of private long-term care insurance policies are usually paid out over a set period of time; meaning there is often a cap on the amount of money which a policyholder may receive.[40] An example of a policy benefit payout can be drawn from Table 1. The average policy in 2000 featured a daily benefit ranging between $106-109, depending on the care setting. In addition, there may be a waiting period imposed before the benefits begin, generally between 50 to 60 days. Finally, there is a maximum to the duration of the benefits; for example, in 2000 the average maximum benefit duration for nursing home placement was 5.5 years.[41]

The final row of Table 1 demonstrates a trend of increasing premiums, factoring in the effects of inflation and policy changes. Premiums, in general, do increase significantly with age. A policy purchased between ages 40 and 50 consumes about 6% of the policyholder's gross income for half of the population in this age bracket.[42] In contrast, the same policy purchased between the ages of 65 and 85 consumes 24% of the gross income for half of the population in this age bracket.[43] In 2002, the annual premium averaged $2,800, which was for a policy that included inflation protection to keep the benefit in line with rising costs of living and non-forfeiture protection.[44]

[39] Cohen, M. (2003).
[40] Alliance for Health Reform.
[41] Alliance for Health Reform.
[42] Alliance for Health Reform.
[43] Alliance for Health Reform.
[44] Alliance for Health Reform.

Due to the fact that "most insurance underwriters assume that a majority of policyholders will drop their policies within five years of the initial purchase" non-forfeiture protection allows these individuals to regain a portion of their loss if they lapse on their policy.[45]

Even without these consumer protections, the premium would be a costly $1,227.[46] Given that the 2005 median household income for Missourians ages 65 and older was $27,122, the expense for a consumer-friendly policy (one that includes inflation protection and non-forfeiture protection) may be too high for the average Missouri older adult.[47]

… nationally only about 10-20% of older adults can afford private long-term care insurance. [47]

In fact, most studies find that nationally only about 10-20% of older adults can afford private long-term care insurance.[48] Additionally, many of the policies' eligibility criteria lead to a denial of private coverage for people with pre-existing chronic care needs.[49] Given the advances of medical science, chronic diseases are being diagnosed earlier and earlier, leading to more people who will be ineligible due to pre-existing conditions. These factors combine to cause more Missourians to be inaccessible to private long-term care insurance by both expense and by exclusion criteria in long-term care insurance policies.

What Are Partnership Programs?

Long-term care insurance partnership programs were developed in the hopes of promoting more state citizens to invest in long-term care insurance. "The long-term care insurance (LTCI) partnership program was developed in the 1980s to encourage people who might otherwise turn to Medicaid to finance their long-term care (LTC) to purchase LTCI. If older adults who purchase qualifying policies deplete their insurance benefits, they may then retain a specified amount of assets and still qualify for Medicaid, provided they meet all other Medicaid eligibility criteria".[50]

The benefit to the consumer is asset protection, and the presumed benefit to the state is a lower number of older adults needing Medicaid financing for long-term care services. As previously stated, there are four states operating long-term care insurance partnership programs: California, Connecticut, Indiana, and New York. These states adopted partnership programs in the 1990s, before a federal law (OBRA-93) was passed that put a moratorium on the implementation of any new LTCI partnership programs. The Deficit Reduction Act of 2005 lifted the moratorium on the remaining states, making it possible for Missouri to consider implementing a partnership program.

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[45] Vitt, Lois A. & Jurg K. Siegenthaler, *Long-term care insurance, private*. Encyclopedia or Financial Gerontology.
[46] Vitt, Lois A. & Jurg K.
[47] Houser, A., Fox-Grage, W., & Gibson, M.
[48] Vitt, Lois A. & Jurg K.
[49] Alliance for Health Reform.
[50] Nelson, B. & Binette, J. (2005). 2005 Missouri member survey on long-term care, assisted living, and Medicaid. Retrieved on January 28, 2007 from http://www.aarp.org/research/reference/memberopinions/mo_member.html

Section 4: The Ideal Long-term Care System and its Stakeholders

The Ideal Long-term Care System: Equitable and Cost Effective

The majority of people who buy long-term care insurance have over $60,000 income, are predominantly white, and would most likely have purchased policies with or without the asset protection incentives.[54]

This Task Force supports a long-term care insurance system that is both equitable and cost effective. We operate within a professional Social Work Code of Ethics that seeks to enhance human well-being while meeting people's basic needs, commits to making systems and policies more socially and economically just, and promotes equitable access to opportunities and resources.[51] With 63% of the population below the typical income threshold for purchasing long-term care insurance; partnership programs present a unique opportunity to fill the gaps in services while protecting people from catastrophic long-term healthcare costs.[52] Yet, research indicates that only a narrow 2.4% of the population in the pilot states have purchased long-term care insurance through partnership programs.[53] The majority of people who buy long-term care insurance have over $60,000 income, are predominantly white, and would most likely have purchased policies with or without the asset protection incentives.[54]

In contrast, Medicaid is the current insurance option for people who are unable to afford or meet the eligibility requirements of private long-term care insurance. In their present forms, private long-term care insurance and partnership programs do not provide a safety net for these people:

- Individuals with pre-existing long-term care needs;
- Younger individuals at risk for long-term care due to family medical history or pre-existing conditions; and,
- Low- and moderate-income aging populations.

Even for those who can afford or are eligible for private long-term care insurance, limited benefits, lack of premium stability, and inadequacy of coverage leave policyholders with insufficient protection over time.[55]

Therefore, in order to maintain equity of opportunity and open the benefits of partnership programs to a larger segment of the population, this Task Force offers supplemental options in order to ensure equity of access to partnership programs. Summarized briefly below and further discussed throughout this brief, the following options would allow greater access to partnership programs:

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[51] Code of ethics of the national association of social workers. http://www.socialworkers.org/pubs/code/code.asp**.** Retrieved on April 10, 2007.

[52] Calculated based on the percentage of the population falling below the minimum income of long-term insurance purchasers, which is $60,000.

[53] Axelrad, J. (2005). CRS report for congress: Medicaid's long-term care insurance partnership program. Retrieved on March 30, 2007.

[54] Axelrad, J. (2005).

[55] Feder, J. (2005). Long-term care: the critical role of public financing. Retrieved on February 11, 2007 from http://www.americanprogress.org

- Suggestions for Proposed Partnership Policies:
  - Stronger State Regulation, Oversight, and Consumer Protection
  - Premium Assistance
  - Tax Credits and/or Tax Deductions
- Suggestions for Supplemental Community Options:
  - Home and Community Based Care Waivers
  - Programs for All-Inclusive Care of the Elderly

In addition to equitable access, these alternatives could also assist people in delaying or avoiding institutional care, which in turn would reduce Medicaid spending on long-term care services in Missouri. One of the goals of Missouri's current legislation is to curtail state Medicaid spending on long-term care services through greater utilization of long-term care insurance.[56] For example, the four states that have piloted the partnership programs have seen a savings of $8-10 million in Medicaid expenditures.[57]

At present, 80,000 people of the state's 786,682 older Missourians with long-term care needs rely on the Medicaid program to fund their long-term care services.[58] Due to the increasing costs associated with long-term care services, more and more people are forced to "spend down" their assets on long-term care services, which often results in eventual reliance on Medicaid.[59] In order for partnership programs to save the state of Missouri money they need to address this segment of the population who, if their long-term care needs were insured, would not have to impoverish themselves in order to qualify for Medicaid funding. By providing greater and more equitable access to long-term care insurance, more Missourians will be able to purchase and rely on their long-term care insurance policies, retain their assets, and delay early spend down for Medicaid insurance coverage – potentially saving the state in Medicaid expenditures.

Identified Stakeholders

As the aging population in Missouri increases, so do those who will be affected by the availability of funding for long-term care services. Long-term care insurance partnership programs can be an option to ease the cost of long-term care for older adults. The quality, availability, and cost of long-term care insurance partnership programs affect a large number of stakeholders.

The Consumers Themselves: Missouri's Older Adults

The most obvious stakeholders in the long-term care system are the consumers themselves. A study conducted by the Agency for Healthcare Policy and Research found that 42% of Americans who reach the age of 70 will require some form of long-term care during the rest of

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[56] Missouri State Government (2007). House bill 40 fiscal note. Retrieved on April 4, 2007 from www.moga.mo.gov
[57] Robert Wood Johnson Foundation, (2007). Grant results topic summary: financing long-term care. Retrieved on March 30, 2007 from http://www.rwjf.org
[58] Missouri Medicaid Basics. (2006). Retrieved February 3, 2007, from http://www.aarp.org/research/
[59] Medicaid Spending on Long-Term Care Varies by State. The Kaiser Commission on Medicaid and the Uninsured., p. ii.

their lifetime.[60] A recent survey of Missouri AARP members reflects the concern surrounding long-term care in the aging community:

- More than three-quarters of members are worried about being able to afford long-term care services for themselves or their family.
- Most members do not own a private long-term care insurance policy. Of those Missouri members who do not currently own a long-term care insurance policy, most say they would not consider buying long-term care insurance because it is too expensive.
- Eighty-five percent of Missouri members would prefer to receive long-term care in their own homes or in home-like settings. Only three percent want to go to nursing homes.
- Eight in ten Missouri members support AARP Missouri advocating to increase funding for long-term care services that help people stay in their homes or communities.
- More than half of Missouri members say they would be more likely to vote for a candidate who supports shifting funds from nursing homes to long-term care services that help people stay in their own homes and communities.
- Three in four members oppose more cuts to Medicaid as a way to balance Missouri's budget.[61]

The common theme heard through the words of Missouri senior citizens is one of worry. Worry for their future and financial stability. Worry about their ability to make decisions regarding their future care and the location where they will receive that care. Worry that much-needed Medicaid funds will be cut in order to achieve a balanced budget.

A long-term care insurance partnership program might help ease worries about long-term care for some Missourians, but a partnership program will still leave a significant proportion of Missouri older adults without the security and assurance that long-term care insurance can provide. Without proper supports and consumer protections premiums will still be too high for many of Missouri's older adults, and their ability to qualify due to health and pre-existing conditions is increasingly limited.

Caregivers

Even though many people have a strong informal support system of family and friends, often eldercare can be "complicated and best provided by trained professionals".[62] This professional care requires monetary resources that otherwise might be used for retirement or left to future generations. This can have far-reaching implications for families, especially considering the growing trend of grandparents raising their grandchildren. If too harshly affected by the loss of even indirect benefits, these children and family members may not be able to rise out of the cycle of poverty; leaving their progeny in danger as well as adding another group of older adults who will need to rely on someone else to make it through their final years. If future generations are not able to save properly for their own retirement because they are economically burdened by their older family members, a vicious cycle will be created. As actuaries Ty Wooldrige and Dawn Helwig indicate:

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[60] Wooldrige, T. & Helwig, D. Dawn (2006). *Long-term Care is Poised for Growth.* Society of Actuaries, http://www.soa.org/ccm/content/about-soa-member-directory/the-actuary-newsletter/april-2006/long-term-care-is-poised-for-growth/.
[61] Nelson, B. & Binette, J.
[62] Wooldrige, T. & Helwig, D. Dawn

The financial implications of this relatively common eventuality can be so catastrophic to a family that no financial plan should be considered complete until it at least contemplates this exposure. Considering that the oldest member of the baby boomers, the largest demographic group in recorded history, turned 60 on January 1 of this year, it is clear that for literally millions of Americans, long-term care will become an expensive reality.

In a 2005 study of over 7,000 long-term care facilities, assisted living facilities, and home healthcare agencies across the country Genworth Financial found an average annual cost of a nursing home stay to be $70,000.[63] In Missouri this figure would be lower, due to the lower cost of living in the state; however, as the chart below shows, long-term care costs are still high even in Missouri and will only rise in the future.

It is clear that for literally millions of Americans, long-term care will become an expensive reality. [63]

Table 2. Long-term care costs: Now and in the future

Type of care	2000	2030
Adult day care	$12,981	$56,100
Homemaker services	$15,110	$65,300
Home health aide	$15,743	$68,000
Assisted living	$25,300	$109,300
Nursing home	$44,100	$190,000

Source: ACLI, 2000

This is a huge cost to be born by the consumers, their support system, and potentially Medicaid. Long-term care insurance can help to cover this cost; however, a majority of older people do not purchase private long-term care insurance, either due to financial restrictions, exclusionary underwriting practices, or lack of awareness of LTCI and its benefits. Only 9.2 million private long-term care insurance policies were sold nationally between 1987 and 2002, and of these only 72% were not allowed to lapse.[64] This is a very small number of purchasers compared to the aging population of the United States, which is currently over 775,000 persons over the age of 65 for the state of Missouri alone. The Missouri Office of Social and Economic Data Analysis (OSEDA) estimated 13.4% of the state's population was over the age of 65 in 2004; a figure that will increase to 15% by 2010 and continue to rise to 18% by 2020.[65,66]

In 2005, approximately 80,000 Missourians aged 65 and over used Medicaid Insurance to finance long-term care services, accounting for one out nine Missouri citizens over the age of 65. Nursing homes provided care for 38,443 individuals, or 4.8% of the senior population in Missouri. Medicaid was the primary payer for 64% of nursing home residents, using $805 million in Medicaid payments.[67] Total spending for the elderly in 2005 was $1,369,283,389 with an average monthly payment per individual of $1,409. Estimates indicate that between now

[63] Wooldrige, T. & Helwig, D. Dawn
[64] Alliance for Health Reform.
[65] Office of Social and Economic Data Analysis, modified 2007. Regional profiles - beyond 2000. Retrieved on February 11, 2007 from http://www.oseda.missouri.edu/regional_profiles/baby_boom_growth_2000_2004.shtml
[66]Missouri Senior Report (2006). Missouri Department of Health and Senior Services.
[67]Missouri Medicaid Basics (2006). Retrieved on February 3, 2007 from http://www.mffh.org/policy_medbasics.htm

and 2030 Medicaid spending will increase by 7 to 9%.[68] Table 3 below provides estimates for future Medicaid long-term care expenditures based on current expenses and future aging trends.

Table 3. Estimated future Medicaid long-term care expenditure

Indicators	2005	2010	2020
Population 65+	786,682	904,684	1,218,637
Population receiving Medicaid insurance	80,000	81,421	109,677
Average monthly cost based on 7% increase	$1,409	$1,507	$1,612
Medicaid expenditures	$1,369 billion	$1,472 billion	$2,121 billion

Source: Estimates used for this table were derived from the Missouri Senior Report 2006, Missouri Department of Health and Senior Services and Missouri Medicaid Basics Report 2006, Missouri Foundation for Health.

The table leaves little room for doubt regarding the impact of an aging population on long-term care spending. The baby boom generation is growing, and as they age one can predict the need for long-term care services will also increase.

Taxpayers

In addition, these findings will have a significant impact on taxpayers. Financially, taxpayers are also stakeholders in this issue. With all of the worry surrounding the increasing aging population and decreasing funds in Medicaid and Medicare, it is important to research options that can help to ensure current and future taxpayers will be able to access Medicaid and Medicare when needed. Long-term care insurance is one option that may help ease the burden on taxpayers of long-term care, but as future sections will show long-term care insurance alone will not be enough; nor will it, in its current state, provide equitably for all older adults. One option for making long-term care insurance more affordable and accessible to Missouri citizens is an LTCI partnership program.

Legislators and State Administrators

Legislators and state administrators are faced with the task of a growing constituency of older adults, and with the rise in the older adult population, a growing number of persons requiring long-term care services. These stakeholders are faced with a population that is living longer, and because of advances in medical technology surviving conditions that in the past may have been fatal. The legislators and state administrators are now challenged with the task of providing for the changing needs of the people of the state of Missouri and must decide if and how they will address the long-term care needs of the citizens of Missouri. They are also challenged by the dwindling Medicare and Medicaid funds and the knowledge that their decisions will affect the future health and welfare of Missourians.

Insurance Industry

The insurance industry has a significant and influential stake in the passage of legislation to create long-term care insurance partnership programs, as evidenced by their strong support of partnership programs. An LTCI partnership program in Missouri would bolster the sales of

[68] Center for Personal Assistance Services (PAS) (2002). Missouri Medicaid 1915(c) waivers. Retrieved on February 26, 2007 from http://www.pascenter.org/state_based_stats/medicaid_waiver.php?state=missouri#p26.9

LTCI policies and provide increased business for the insurance industry in Missouri. The insurance industry also has a stake in the format and regulations of the LTCI partnership program. For example, if the partnership program places a great deal of regulation and consumer protection in the legislation, then the insurance industry's sales of policies may be affected.

Service Providers

Finally, service providers are also stakeholders in the partnership program legislation. Providers of long-term care services could potentially witness their number of customers increase if more people have long-term care insurance. Informal caregiving hours could be reduced or relocated to formal service providers if the funds were available through a long-term care insurance policy. Service providers might be overwhelmed by increasing numbers of clients, and could also see an increase in their industry and competition if more Missourians had the private funds (through an LTCI policy) necessary to pay for formal long-term care services.

Overall, there are several key groups who have interests in a Missouri partnership program, and there needs and wants fall across a spectrum of demands. However, the unifying factor is the degree in which they will be affected by a potential partnership program.

Section 5: Quality of LTCI Partnership Programs

What Services Does a Typical Policy Cover?

Each insurance policy in partnership programs varies, as different consumers have different long-term care needs. Insurance policies are formed by the combination of benefits and coverage, such as: types of benefits, length of coverage, elimination periods, non-forfeiture protection, and inflation protection (see Appendix B).

What to Consider When Choosing a Long-term Care Insurance Policy

In general, it is important for consumers of long-term care insurance, within a partnership program or not, to be familiar with the terms listed above when determining the quality of a specific policy. For an illustration of an ideal long-term care insurance policy that takes into account the best interest of the consumer see Appendix B. The following section provides an overview of key policy terminology to consider when purchasing long-term care insurance. Of particular note are the non-forfeiture protections, benefit triggers, and benefit waiting periods or elimination periods. In addition, the quality of services provided by a particular policy may be irrelevant if the insurance company providing the policy no longer exists when the purchaser is ready to access benefits. Therefore, the financial strength of the insuring institution is another important factor to consider.

Covered Benefits

The policyholder has choice regarding the location of benefit receipt, such as the option to receive: home care only, nursing home care only, or both home and nursing home care. The majority of policies that have been sold under the partnership programs in the four pilot states include both nursing home care and home care.

Length of Coverage

The consumer also has variety in the duration of coverage periods in policies, such as: one, two, three, four and five years, or even the option of lifetime coverage. For example, eighty percent of partnership policies sold in Indiana cover five years of services or more, and only 6% cover less than three years. In contrast, in California only 31% of policies cover five years of services or more. In Connecticut, 67% of policies provide less than four years of provision coverage, and in New York it is required to cover a minimum of three years of nursing home coverage and/or six years of home care coverage under the state's total asset protection model.

Elimination Periods

Elimination periods are the length of time that policyholders have to wait to receive benefits after meeting eligibility criteria. Because of the expectation that the first ninety days of payments will be covered by Medicare if the insured is institutionalized, the majority of people in California, Indiana, and New York have purchased policies with 90-day elimination periods for nursing home coverage. In contrast, of the policies that have been sold in Connecticut, only 43% include a 90-day elimination periods.

Non-Forfeiture

If policyholders fail to pay premiums, non-forfeiture protection allows them to be eligible for reduced benefits, a shortened coverage period, or recuperation of a portion of their investment. For example, all policies sold in California are required to have non-forfeiture protection. On the other hand, 99% of the policies that have been sold in Connecticut and Indiana have no non-forfeiture protection. In New York, about half of the policies do not have non-forfeiture protection.

Inflation Protection

All policies that have been sold to persons 70 years old and younger in California, and 80 years old and younger in New York, are required to have inflation protection. In Connecticut and Indiana, all policies are required to have inflation protection, regardless of the age of the policyholder.[69]

Implications and Recommendations for Missouri

As of January 2005, approximately 181,600 partnership policies have been purchased across the four pilot states; with a rate of 16% of applicants being denied LTCI partnership program policies through the insurance underwriting process.[70] A survey report from the Connecticut partnership program found that their state alone had a denial rate of 12.5%.

Additionally, 27% of those surveyed who reported initial denial were then granted LTCI through partnership programs upon re-application. Based on these statistics, it is apparent that there are significant discrepancies among the underwriting procedures used by the insurers within the LTCI partnership programs.

To improve quality and access, Missouri should consider implementing the following quality measures:

- Closely monitor the denial rates and reasons for denial within the proposed LTCI partnership program;
- Establish an independent review board that reviews denied claims to ensure the underwriting process maintains ethical standards within the partnership program;
- Implement a consumer hotline to assist partnership program applicants;
- Provide education on the policyholders' right to appeal denial decisions and reapply to different insurance companies within the partnership program.

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[69] Congressional Research Service. (2005). Medicaid's long-term care insurance partnership program.
[70] Alliance for Health Reform (2007). Long-term care partnerships: An update. Retrieved on March 20, 2007 from http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=43653

Section 6: Access to LTCI through Partnership Programs

Who Purchases LTCI Partnership Policies?

The four pilot states offer insight into access to LTCI through the partnership programs. Long-term care insurance partnership programs were designed to improve access to care and protect consumers from the mounting costs of long-term care through the promotion of long-term care insurance. An additional benefit of the resulting increase in the number of people insured through the private market would be cost-savings for Medicaid. Furthermore, the asset protection provided through partnership policies was meant to prevent people from transferring their assets to qualify for Medicaid.[71]

As the partnership program was designed, the asset protection was expected to be the incentive for people to purchase long-term care insurance who might not have otherwise purchased such a policy.[72] An additional desired outcome of the partnership programs was an increase in younger people purchasing long-term care insurance. The partnership programs were designed in such a way that Medicaid would be open to potential financial loss; if, for example, purchasers of partnership policies have such high levels of income and assets that they would never have otherwise qualified for Medicaid without the partnership program's asset protection. Therefore, in order for states to realize a financial benefit through the partnership, a large number of purchasers need to fall below a certain income and asset threshold.

Data from the four pilot states offers valuable information about who has been able to access long-term care insurance through the partnership program. As of 2005, the number of partnership policies sold number 181,600, with 149,300 of these still active. Surveys of purchasers in California, Connecticut, and Indiana show that over half of all purchasers hold assets greater than $350,000; not including their home. Twenty percent of purchasers in Connecticut and California are recorded as having less than $100,000 in assets, home excluded.[73] Similarly, close to half of purchasers in California and Indiana report having monthly income in excess of $5,000 or an annual income of $60,000. Meanwhile, half of Connecticut purchasers report having less than $2,500 in monthly income, or an annual income of $30,000.[74]

> ***Surveys of purchasers in California, Connecticut, and Indiana show that over half of all purchasers hold assets greater than $350,000; not including their home.*** [73]

[71] Ahlstrom, A., Clements, E., & Tumlinson, A. The long-term care partnership program: Issues and options. George Washington University School of Public Health and Health Services; Washington, D.C.
[72] Stone-Axelrad, J. (2005) Medicaid's long-term care insurance partnership program. Congressional Research Service, Domestic Social Policy Division, The Library of Congress.
[73] Stone-Axelrad, J.
[74] Stone-Axelrad, J.

Table 4. Income and assets at time of purchase (Purchaser surveys conducted by states)

State	Average monthly household income	Assets (excluding home)
CA (n=629)	Less than $2,000: 5% $2,000-5,000: 37% Greater than $5,000: 58%	Less than $100,000: 21% $100,000-350,000: 33% Greater than $350,000: 46%
CT (n=699)	Less than $2,500 : 57% $2,500-5,000: 14% Greater than $5,000: 14%	Less than $100,000: 19% $100,000-199,999: 17% $200,000-350,000: 17% Greater than $350,000: 48%
IN (n=576)	Less than $3,000: 17% $3,000-5,000: 34.5% Greater than $5,000: 43% Unknown: 5.5%	Less than $50,000: 0.8% $50,000-199,999: 13% $200,000-350,000: 21% Greater than 350,000: 60% Unknown: 5.2% (Own home: 94%)

Sources: Purchaser Survey 2002, California Department of Health Services, California Partnership for Long-term Care: Annual Report, October 2003; Annual Report for The Connecticut Partnership for Long-Term Care Research: Evaluation Studies. July1, 2001-June 30, 2003. Issued October 2003; and Indiana Purchaser Survey 2002 of 576 respondents. (Taken from Stone-Axelrod, J., CRS Report for Congress, 2005.)

Note: Variations in data reported reflect differences in the way each state collects and reports data. NY has not conducted a purchaser survey since 1995 and is thus not included in this table.

Table 4 shows the income and assets of partnership policy purchasers at the time of purchase in Connecticut, California, and Indiana. The table does not include information about New York. More recent data from Connecticut indicates a shift in the income and asset level of purchasers in this state, resulting in 10% of policyholders reporting less than $2,500 in monthly income, and 61% reporting more than $5,000 in monthly income. This more recent data also indicates a shift in asset level, with 58% of policyholders reporting assets exceeding $350,000, and 13% reporting assets below $100,000, which leaves 30% to fall in between.[75]

There is limited data available on the age of partnership policy purchasers, but what data has been collected show that these purchasers are slightly younger than those purchasing long-term care insurance in general.[76] Table 5 below contains demographic data on the partnership policies in all four of the pilot states. While the median and average ages of policy purchasers in all four states range between 58 to 64 years old, Indiana and New York report having purchasers at age 19.[77] Overall, the data indicates that a majority of purchasers are female with an average age of 67. Likewise, two-thirds of purchasers are married.[78] More recent data from Connecticut

[75] Annual report for the Connecticut partnership for long-term care, Evaluation Studies, July 1, 2004 – June 30, 2005.
[76] Stone-Axelrod, J.
[77] Stone-Axelrod, J.
[78] Stone-Axelrod, J.

indicates only a slight difference in the median age of purchasers, which increased to 59.[79] Similarly, 54% of policyholders report being female, and 75% report being married.[80]

Table 5. Demographics of partnership plan buyers (at time of purchase)

State	Age	Gender	Marital status
CA (as of 12/03)	Median age: 61 Ages 55-74: 71% Other ages: 29%	Female: 59% Male:41%	Married: 69% Not married: 30% Unknown: 1%
CT (as of 12/03)	Average age: 58	Female: 56% Male: 44%	Married: 77% Not married: 12% Unknown: 8%
IN (as of 03/04)	Average age: 62 (Age range: 19-90)	Female: 57% Male: 43%	Married: 77% Not married: 22% Unknown: 1%
NY (as of 09/03)	Median age: 64 Minimum age: 19 Maximum age: 93	Female: 60% Male: 41%	Married: 71% Not married: 26% Unknown: 3%

Sources: (Taken from Stone-Axelrod, J., CRS Report for Congress, 2005.)

Who is Left Out?

In addition to offering insight into those persons who access LTCI through partnership programs, the pilot states also offer a glimpse into who the partnership programs exclude. Two major factors affect accessibility of these policies. The first of these factors is the affordability of premiums. The other is who is actually qualifying for the policies, which is determined by such factors as the purchaser's age, health status at the time of purchase, and the benefits covered by the policy. Age also impacts the affordability of premiums. As Table 6 illustrates, premiums for long-term care insurance policies increase with age. This fact alone not only impacts the affordability of long-term care insurance policies at the time of purchase; but, in addition, (because long-term care insurance benefits are usually not accessed until years after the purchase) the age-premium relationship affects the ability of the purchaser to retain the policy as he/she ages.

[79] Annual report for the Connecticut partnership for long-term care.
[80] Annual report for the Connecticut partnership for long-term care

Table 6. Average annual premiums for top long-term care insurance sellers in 2002

Age	Base	With compound inflation protection	With a non-forfeiture benefit	With compound inflation protection and non-forfeiture benefit
40	$422	$890	$537	$1,117
50	$564	$1,134	$715	$1,474
60	$1,337	$2,346	$1,646	$2,862
79	$5,330	$7,572	$6,479	$8,991

Source: Taken from Stone-Axelrod, J., CRS Report for Congress, 2005. America's Health Insurance Plans, Long-term care insurance in 2002: Research Findings, Washington, D.C., June 2004.

There are also policy implications to this age-premium relationship, adding importance to the inclusion of non-forfeiture benefits and inflation protection in state-qualified policies. Purchasers with non-forfeiture protection can still access the same **or** lower level of benefits if they are unable to maintain their premium payments resulting in lapsed policies.[81] Inflation protection, as identified by the National Association of Insurance Commissioners (NAIC) model standards for long-term care insurance partnership policies, are typical of partnership policies offered in the pilot states and, as the name implies, protect the policyholder from increases in premiums due to inflation. It is important to note that inflation protection is selectively offered to various age cohorts varying by state.[82]

Table 6 shows the significant increase in premiums both with age and with the consumer protections (e.g. inflation protection) included. Insurance providers generally discourage purchasing a policy if its cost exceeds 7% of the purchaser's income. Therefore, Table 6 also reveals two populations who are unable to access long-term care insurance partnership policies, due to the expense: persons of increased age and low-income persons.

The most recent evaluation of the Connecticut Partnership for Long-term Care reveals other populations who are unable to access long-term care insurance through the partnership program. In Connecticut, 12.5% of policy applications were denied between 1992 and 2005. In real numbers, that represents 5,990 policies denied.[83] Surveys were administered to those denied, with a 28% response rate, resulting in 1,678 surveys answering why these policies were denied. It is interesting to note that the Connecticut Partnership requires of its providers that if they deny an application, they must send the denied applicant this survey along with the denial letter. This denial letter, however, does not have to specify the reason for denial.[84]

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[81] Stone-Axelrad, J. (2005) Medicaid's Long-Term Care Insurance Partnership Program. Congressional Research Service, Domestic Social Policy Division, The Library of Congress.
[82] Stone-Axelrad, J. (2005) Medicaid's Long-Term Care Insurance Partnership Program. Congressional Research Service, Domestic Social Policy Division, The Library of Congress.
[83] Annual report for the Connecticut partnership for long-term care. Evaluation Studies, July 1, 2004 – June 30, 2005.
[84] Annual report for the Connecticut partnership for long-term care.

These surveys indicated that 87% of those applicants denied believed themselves to be in good or excellent health. However, 65% indicated that they believed a health condition was the reason they were denied long-term care insurance partnership policies. Twenty-six percent marked "other" as the reason for denial, and this category includes a "health-related condition under control."[85] The remainder of respondents marked age (1%), unknown (22%), and incomplete application (1%) for the reason of their denial.

Another interesting feature of the Connecticut partnership is that denied applicants can request that the specific reason for denial be relayed to their personal physician by the denying company.[86] The exclusion of persons with pre-existing health conditions, whether justified or not, is worth considering, particularly as medical science advances and earlier diagnoses of conditions requiring extensive long-term care services increases (e.g. Alzheimer's disease).

The axes of quality, accountability, and access unite when it comes to the ability of the policyholder to access benefits. In the case of the partnership, these benefits can either be accessed through the private long-term care insurance policy or through Medicaid when those benefits have been exhausted. Accountability as it applies to the policyholder's ability to access benefits will be discussed in more depth in a subsequent section. As for the policyholders in the four pilot states, the following data gives a glimpse at benefit use of the partnership policies. As of January 2005, approximately 181,600 partnership policies had been purchased cumulatively in all of the pilot states. Of these, 1.2% (2,200) policyholders accessed benefits through their private long-term care insurance policies, and 0.5% (88 persons) exhausted their private benefits, eventually relying upon Medicaid for their long-term care services.[87]

Implications and Recommendations for Missouri

After careful review of the data provided on those who hold and who have been denied long-term care insurance partnership policies in the pilot states, the task force recommends consideration of the following options to improve access to partnership policies in Missouri. These recommendations may be taken as a whole or a la carte and are created to meet the needs of the populations who might not otherwise access these policies due to their affordability or due to qualifying conditions. The recommendations for improving access to long-term care partnership policies in Missouri are as follows:

- Provide denied applicants with information and opportunities for appeal through:
    - Establishing an independent review board so that individuals who are denied coverage can appeal to an impartial body of experts, including providers and consumer representation;
    - Requiring insurance providers to provide the denied applicant with the specific reason for denial, either directly or through their personal physician.

[85] Annual report for the Connecticut partnership for long-term care.
[86] Annual report for the Connecticut partnership for long-term care.
[87] Stone-Axelrad, J.

- Provide enhanced incentives to purchase long-term care insurance partnership policies by:
    - Providing deductions through cafeteria plans and flexible spending accounts through employers;
    - Allowing premium payments without penalty from IRA, 401(k), and similar tax-deferred retirement accounts;
    - Offering a tax credit in addition to the tax deduction; the tax credit would provide a greater benefit to those with lower incomes.[88] A more in-depth explanation of why tax credits are more effective at targeting the population of purchasers with lower incomes follows.
    - Subsidizing the purchase of long-term care insurance policies through offering means-tested individuals premium assistance through subsidies paid directly to the provider. This can be done in lieu of a tax credit, so the cost to the state would be comparable. But, the state can be assured that the money it has earmarked for long-term care insurance is spent appropriately, since it will be providing the payment directly to the insurance policy provider.

A Case Study: Ethel

The following is an example of an average purchaser of long-term care insurance through the partnership program. Ethel is a 50-year-old woman who purchases a partnership program in 2007 with an annual premium of $1,474 and three years of policy protection. Twenty years later, she has a stroke and requires in-home services to provide long-term care. At the time of her stroke, she has $100,000 in assets. The estimated monthly cost of long term care in 2027 is $1,724 or $20,688 per year. For the next 36 months, she is provided coverage through her LTC partnership policy. At the end of the 36 months, she is eligible to protect a total of $62,064 of her assets based on the value of her LTC partnership policy. For the next 22 months, she uses her assets to pay for her long-term care. At this time, she has spent down her assets to $62,064 and is now eligible for Medicaid Insurance. The total estimated savings for Missouri is $66,098 for this one individual. However, this one individual spent a total of $71,838 on premiums and out-of-pocket expenses combined, to save a total of $62,064 in assets.

Table 7. Ethel's case study

A	B	C	D	E	F
Total Premium Paid	Total Asset Protection	Total Tax Deduction	Total Payout By Policy	Total Out-of Pocket Expenses	Total Savings for Missouri
33,902	62,064	33,902	62,064	37,936	66,089

NOTE: To determine the overall savings to Missouri we used the following formula from the table above: D+E-C=F. This formula accounts for the Policy Coverage, Out-of-Pocket Expense and Tax Deduction amount give this individual.

[88] Frakt, A. & Pizer, S.

While Ethel actually spent more on her long-term care, including insurance and care costs, the state of Missouri actually saved money on her long-term care needs thanks to Medicaid's financial eligibility requirements, as well as Ethel's carefully accrued lifetime savings. This case study illustrates the potential impact of a partnership program on Missouri's state budget from one individual case, which brings into question the economic impact of these partnership programs on the four pilot states. For partnership programs to be deemed a success, not only should they result in a change in the demographics of the purchasers, as mentioned previously, but they should also result in significant cost-savings to the states in which they have been implemented. A review of the data gathered in each of the four pilot states may shed some light on the true economic impact of the long-term care insurance partnership programs and whether or not they are fulfilling their desired goal.

Section 7: The Economics of LTCI Partnership Programs

Economic Impact of Partnership Programs in California, Connecticut, Indiana & New York

The LTCI partnership program model started nineteen years ago. A 2006 summary report on the partnership programs reveals a total of 181,600 partnership policies purchased in the four original partnership states, accounting for an estimated $8 to $10 million in Medicaid savings from the four partnership states.[89]

The following example of savings is based on findings from a report on the California partnership program; where eighteen individuals who enrolled in the partnership program eventually qualified for Medicaid Insurance. Each of the individuals spent on average 26 months in the nursing home for a combined total of 466 months, at a cost of approximately $4,415 a month per individual. California estimated a savings of $1.3 million in potential Medicaid savings as a result of participation in the partnership program. It should be noted that the report did not indicate whether eighteen individuals had transferred assets before applying for Medicaid Insurance.

Characteristics of the eighteen individuals include:

- An average of $19,000 in assets per person;
- Approximately 26 months of nursing home care per person.[90]

Without California's LTCI partnership program, it is predicted that these same eighteen people would have had the assets to cover approximately five months of their stay in a nursing home. After the spend-down of assets they would be eligible for Medicaid Insurance; resulting in a Medicaid Insurance expenditure equaling approximately $1.6 million. Based on this data, potential savings result through partnership program purchases made by people who are at risk for early asset spend down and eventual Medicaid Insurance coverage for long-term care.

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[89] Robert Wood Johnson Foundation, (2007). Grant results topic summary: financing long-term care. Retrieved on March 30, 2007 from http://www.rwjf.org

[90] Axelrad, J. (2005). *CRS report for congress Medicaid's long-term care insurance partnership program*. Retrieved on March 30, 2007 from http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3261001212005.pdf

Costs to the Individual

Table 8. Cost of long-term care insurance partnership program by age (dollar)[91]

Age	Minimum premium	Maximum premium	Range
40	422	1117	695
50	564	1,474	910
65	1,337	2862	1525
79	5,330	8991	3661

Source: America's Health Insurance Plans, *Long-Term Care Insurance in 2002: ResearchFindings*, Washington, DC, June 2004. As cited in Axelrad J. 2005.

The costs of LTCI partnership programs vary based on age, health status, family health history, and the type of policy protection purchased. For a 40-year-old the annual premiums range from $422 to $1,117; at age 50 the annual premiums range from $564 to $1,474; at age 65 the annual premiums range from $1,337 to $2,862; and, at age 79 the annual premiums range from $5,330 to $8,991.[92] At a younger age, the premiums may seem quite reasonable, but for an older adult in search of resources to provide for long-term care needs, the price of an LTCI partnership program's premiums becomes increasingly cost prohibitive.

The partnership programs are said to be targeted at lower- to middle-class families. The goal is to provide asset protection as an incentive to purchase the policies, thus reducing early asset transfer and delaying Medicaid spend-down. The U.S. Census does not have an official definition of middle-class, but the commonly held definition describes the middle-class individual as having $25,000 to $100,000 in annual income.[93] This income range may be more accurately depicted as lower-middle, middle, and upper-middle income levels. As the following table depicts, there is a drastic difference between an annual household income of $25,000 versus $100,000.

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[91] America's Health Insurance Plans, *Long-term care insurance in 2002: Research findings*, Washington, DC, June 2004. As cited in Axelrad J. 2005.
[92] America's Health Insurance Plans.
[93] Drum Major Institute for Public Policy (2004). Myth of the Middle Class. Retrieved on February 11, 2007 from http://www.drummajorinstitute.org

Table 9. Household incomes and expenses

	National average % of income	100% Federal Poverty Level 2007 Family of 2	200% Federal Poverty Level 2007 Family of 2	300% Federal Poverty Level 2007 Family of 2	Missouri median household income 2005	Typical household income of LTCI partnership purchaser	Upper-middle class income level
Income		$13,690.00	$27,380.00	$41,070.00	$44,324.00	$60,000.00	$100,000.00
Expenses							
Housing &utilities	32.0%	$4,380.80	$8,762.00	$13,142.00	$14,183.68	$19,200.00	$32,000.00
Transportation	18.0%	$2,464.20	$4,928.00	$7,393.00	$7,978.32	$10,800.00	$18,000.00
Medical	5.9%	$807.71	$1,615.00	$2,423.00	$2,615.12	$3,540.00	$5,900.00
Food	13.3%	$1,820.77	$3,642.00	$5,462.00	$5,895.09	$7,980.00	$13,300.00
Entertainment	5.1%	$698.19	$1,396.00	$2,095.00	$2,260.52	$3,060.00	$5,100.00
Miscellaneous	14.5%	$1,985.05	$3,970.00	$5,955.00	$6,426.98	$8,700.00	$14,500.00
Personal insurance, Social Security & savings	11.1%	$1,519.59	$3,039.00	$4,559.00	$4,919.96	$6,660.00	$11,100.00
Total expenses		$13,676.31	$27,353.00	$41,029.00	$44,279.68	$59,940.00	$99,900.00
Total income after expenses		$14.00	$27.00	$41.00	$44.32	$60.00	$100.00
LTCI at 7% of income		$958.00	$1,917.00	$2,875.00	$3,102.68	$4,200.00	$7,000.00

Source:
The Access Project (2007). Federal Poverty level. Retrieved on April 19, 2007 from http://www.atdn.org/access/poverty.html
U.S. Census (2005). Income. Retrieved on April 19, 2007 from **http://www.census.gov/**
Money Zine (n.d.). National average family budget. Retrieved on April 19, 2007 from www.money-zine.com/download/Average-Family-Budget.xls
Missouri Department of Insurance (2007). Long term care insurance personal worksheet. Retrieved on April 19, 2007 from http://www.insurance.mo.gov/industry/filings/ltc.htm

As Table 9 shows, there are set expenses that a household must incur, such as housing and utilities, food, insurance, and transportation. Budgeting for LTCI partnership policies would most likely require families to draw down from their miscellaneous expenses. Families in the lower-income brackets have comparably less miscellaneous income than those in the upper-income brackets. Therefore, the ability to budget no more than 7% of one's household income for LTCI is an increased hardship for lower-income households and older adults, who are often on fixed incomes. Partnership programs must produce equitable incentives to reach those in the lower-income levels and older adults who are most at-risk for early Medicaid spend down due to limited income and asset levels.

Costs to Missouri

Table 10. Revenue reduction by LTCI partnership program (dollar)

Year	Reduction	Additional expense of Department of Insurance
2008	2,800,000	42,638
2009	2,800,000	50,020
2010	2,800,000	51,288
Total	8,400,000	143,946

Note: Additional expense of Department of Insurance is for hiring of an additional employee and related equipment and expense.
Source: Missouri State Government (2007). House bill 40 fiscal note. Retrieved on April 4, 2007 from www.moga.mo.gov

The Missouri state legislature has estimated that an LTCI partnership program will result in a reduction of revenue in the amount of $2.8 million each fiscal year (FY) beginning in 2008, 2009, and 2010, for a total revenue deduction of $8.4 million. The Department of Insurance estimates an additional expense of $42,638 for FY 2008; $50,020 for FY 2009; and $51,288 in FY 2010 for the hiring of an additional employee and related equipment and expense.[94]

The partnership program will take time to develop and promote. As has been shown in the four model states, it took nineteen years for the four states to recognize a combined savings of 8 to 10 million dollars. Furthermore, Connecticut has estimated a 6.8% savings to Medicaid per year by 2016-2020.[95] Achieving results that offset the revenue deduction and Medicaid savings will require a well-executed consumer education plan geared toward middle-and lower-income Missourians, who most at-risk for early spend-down and eventual Medicaid Insurance coverage.

As has been shown in the four model states, it took 19 years for the four states to recognize a combined savings of 8 to 10 million dollars. [95]

Based on the Connecticut estimate of 6.8% Medicaid savings, we predict that Missouri would need to have 7,458 individuals with active LTCI partnership policies paying their long-term care expenses by the year 2016-2020, in order to recognize this level of savings. To arrive at this calculation, the following predictions are used. By 2020 it is anticipated that Missouri will be providing long-term care services through Medicaid Insurance to approximately 109,677 individuals, at an average yearly rate of $19,344, for a total expenditure exceeding $2,121 billion. A 6.8% Medicaid savings would amount to over $144 million.

This estimate is based on the following formula:

$\$2{,}121{,}591{,}888^{\text{(2020 Medicaid Cost)}} \times 6.8\%^{\text{(Estimated \% Savings)}} = 144{,}268{,}248^{\text{(Total Savings)}}$

$\$144{,}268{,}248^{\text{(Total Savings)}} \div \$19{,}344^{\text{(Average Yearly Rate)}} = 7{,}458^{\text{(LTCI Policies Resulting in Savings)}}$

[94] Missouri State Government (2007). House bill 40 fiscal note. Retrieved on April 4, 2007 from www.moga.mo.gov
[95] Niesz, H. (2006). OLR research report: Long term care insurance. Retrieved on April 22, 2007 from http://www.cga.ct.gov/2006/rpt/2006-R-0272.htm

How Equitable Are Costs to Missourians?

The legislation proposed in Missouri calls for a 100% tax deduction for the LTCI partnership program. Tax deductions traditionally benefit higher-income individuals more than lower-income individuals. By definition, tax deductions reduce the total amount of taxable income, where tax credits reduce the tax liability or provide an increased tax refund. For lower-income and older individuals, tax credits are viewed as a better tool for stimulating the purchase and continued payment of premiums. This would help to explain the participation rates of the four pilot partnership states. Characteristics of the average purchaser include 42% with yearly incomes at or more than $50,000 per year, and 17% with yearly incomes below $25,000. To date, the existing partnership programs have been most popular among individuals with assets at or above $100,000. Approximately 13.6% of all partnership policies have been purchased by individuals with assets below $100,000.[96]

The higher the income and asset level, the less likely a partnership program participant will be eligible for Medicaid Insurance during his/her life time. If the majority of individuals purchasing Partnership Programs never qualify for Medicaid Insurance based on income and asset levels; then, in effect, tax deductions targeted at the wrong population will do little to decrease the overall spending results of Medicaid Insurance. Effectively reducing the cost of Medicaid Insurance depends on increasing the amount of purchases made by middle- and lower-income and asset holders.

Increasing Access to LTCI Partnership Programs through Tax Credits

Improving access to LTCI partnership programs for middle- to lower-income individuals has the potential to increase the savings associated with Medicaid Insurance through the addition of a tax credit. An analysis of tax deductions versus tax credits has revealed promising results that could increase Missouri's potential for asset protection and Medicaid Insurance savings.

[96] Axelrad, J. (2005).

Table 11. Long-term care market penetration and probability of lapsing by income in 2025 under tax credits and tax deductions

	Tax credits		Tax deductions	
Income as fraction of FPL	Market penetration	Probability of lapsing	Market penetration	Probability of lapsing
0.0-0.99	15%	6%	4%	56%
1.0-2.99	18%	5%	18%	10%
3.0-4.99	23%	2%	34%	2%
5.0 and above	25%	0.50%	43%	1%

Notes: The Federal Poverty Level (FPL) is about $8,750 for an unmarried individual with no dependents (in year 2000). In 2007, the FPL for a single individual is $10,210 an a married household of 2 is $13,690. For a household of 2, the FPL at 3.0 or 300% is $41,070.

Tax credit and tax deductions policies fully phased in by 2010.

Sources: AHCA LTC simulator.

An analysis of this table shows that tax credits greatly increase the market penetration of lower-income and older individuals due to the increased assistance provided for purchasing LTCI through partnership programs. Tax credits not only increase market penetration, but they also reduce the number of lapsed policies among the low-income and older adults. The combination of increased market penetration and a reduced lapse rate results in increased savings to the federal Medicaid budget by 2010.[97] Tax deductions result in a savings of $.08 in 2025 and $.079 in 2050 for every dollar lost through the tax deductions. In contrast, tax credits save Medicaid $1.16 in 2025 and $2.67 in 2050 for every dollar lost through the tax credit. A tax credit not only encourages the purchasing of LTCI through partnership programs by a larger proportion of middle-, lower-income and older individuals, but it also results in greater savings. This savings is attributed to the fact that tax credits effectively reach the intended target audience of those with lower incomes and fewer assets.

Based on this data, those most at-risk for lapsing LTCI partnership policies under tax deductions are individuals with incomes at or below 3.0 or 300% of the Federal Poverty Level (FPL). An additional factor to consider is that 57% of all Missouri older adults over age sixty-five are at or below 300% of the poverty level.[98]

LTCI partnership policies offered through a tax deduction have an average market penetration rate of 11% with a lapse rate of 33% for individuals at or below 300% of the FPL. On the other hand, tax credits are shown to not only increase the market penetration of low-income individuals to 16.5%, but also greatly reduce the lapse rate to an average of 5.5%.

The impact in Missouri of a tax credit versus a tax deduction is best examined through comparing the potential market penetration and lapse rates of lower-income Missourians, who are most at-risk for future spend-down coverage forcing the use of Medicaid Insurance for long-term care services. According to the most recent data, in 2005 there were 721,138 Missourians

[97] Frakt, A.B. & Pizer, S. D.

[98] Missouri Medicaid basics. (2006). Retrieved February 3, 2007, from http://www.aarp.org/research/

over the age of 65.[99] Additionally, 57% or 411,084 were at or below 300% of the federal poverty level (FPL).[100]

Under a tax deduction with a market penetration rate of 11%, 45,219 individuals are estimated to purchase LTCI partnership policies with 33% or 14,922 lapsing the policy over time. In comparison, under a tax credit, 67,828 individuals are estimated to purchase LTCI partnership policies with a lapse rate of 5.5% or 3,730 lapsing their policies over time. The tax credit on average would encourage and sustain an overall purchase rate of 64,097 LTCI partnership policies.

Taking this analysis a step further, Missouri currently covers the cost of long-term care services for 1 out of 9 Missourians; or 80,000 people over the age of 65 at an average monthly rate of $1,409, or $16,980 per year.[101] Had these 80,0000 Missourians had the opportunity to purchase LTCI partnership policies, the anticipated participation rate minus the lapse rate would have the potential of covering 12,474 individuals who are currently using Medicaid Insurance. The potential savings to Medicaid Insurance is $210.6 million a year by effectively targeting lower-income individuals through the use of a tax credit.

The potential savings to Medicaid Insurance is $210.6 million a year by effectively targeting lower-income individuals through the use of a tax credit.

It is important to note that the data presented above is based on assumptions and the best-case scenario. It becomes impossible to predict exactly how many people can truly afford LTCI offered through partnership programs over the long run. In the end, the decision to purchase long-term care insurance is a personal decision, which must be weighed carefully by the individual. For Missourians with upper-middle to upper-class incomes, long-term care insurance may be a sound investment as they plan for their health and financial well-being across the life span. But measuring the true economic gain of an LTCI partnership program remains unpredictable; and in the end depends on a number of variables including:

- Effectively educating Missourians on the need to purchase LTCI partnership program policies.
- Effectively targeting Missourians who can afford to purchase partnership programs policies but would otherwise rely on Medicaid Insurance for their long-term care service needs.
- The ability for partnership program purchasers to continually pay premiums and keep their policies active.
- Missouri's ability to effectively track the cost benefits versus potential revenue loss through asset protection and tax deductions.

To date the current LTCI partnership programs in California, Connecticut, and Indiana, and New York have had limited market penetration, which has, in turn, created limited gains in

[99] United States Census (2005). Fact Finder. Retrieved on April 10, 2007 from http://www.factfinder.census.gov
[100] Houser, Fox-Grage, and Gibson (2005). Across the states profile of long term care. Retrieved on February 3, 2007 from http://www.aarp.org/research/
[101] Missouri Medicaid Basics.

Medicaid savings. The following table is an example of how a tax credit schedule could be implemented.

Table 12. Tax credit schedule

Income as fraction of FPL	Tax credit as percentage of premium
0.00-0.49	100%
0.50-0.99	60%
1.00-1.99	35%
2.00-2.99	15%
3.00 and above	0%

Notes: The Federal Poverty Level (FPL) is about $8,750 for an unmarried individual with no dependents (in year 2000). In 2007, the FPL for a single individual is $10,210 an a married household of 2 is $13,690. Four a household of 2, the FPL at 3.0 or 300% is $41,070.[86]

Sources: AHCA LTC simulator.

This Task Force encourages Missouri to implement a tax credit targeted towards lower-income individuals to increase the equity and extend the participation rates of an LTCI partnership program across all income brackets.

Section 8: How Do We Keep Partnership Programs Accountable?

Insurance Standards & Consumer Protections

When the Deficit Reduction Act of 2005 made it possible for all states to adopt partnership programs, certain standards were required of any new partnership program in order to provide consumer protections. In order to implement partnership programs, standards mandate that states meet the following requirements:

1. The insured was a resident of the state when coverage became effective;
2. The policy is tax-qualified;
3. The policy meets certain specified consumer protection requirements of the NAIC Long Term Care Insurance Model Act and Regulation;
4. The policy contains specified inflation protection if sold to an individual under age 76;
5. The state Medicaid agency provides information and technical assistance to the state insurance department (DOI), on the DOI's role of assuring that producers of partnership policies are trained;
6. The issuer provides regular reports to the Secretary of the Department of Health and Human Services (HHS) (to be set by the Secretary in regulation); and,
7. The state does not impose any requirements on a partnership policy that it does not impose on other LTC policies.[102]

The National Association of Insurance Commissioners (NAIC) also offers standards of insurance products, called Model Act and Regulation, for the purpose of promoting consumer protection and maintaining the insurance industry's reliability.[103] The NAIC Model is reflected in many states' legislation and regulation for long-term care insurance, and these standards include:

- Suitability: standards to help applicants decide whether a policy is appropriate and affordable;
- Replacement: standards designed to help applicants decide whether they should replace an old policy with a new one;
- Prohibition against post-claims underwriting: standards to prevent insurers from performing underwriting after a policy has been purchased and a claim has been filed;
- Benefit triggers: standards specifying minimum benefit triggers.[104]

Regulation & Oversight

The New York Times recently ran an article titled, "Aged, Frail, and Denied Care by Their Insurers." The story of Mary Rose Derks is featured in this article and serves as a cautionary tale illustrating the importance of public regulation and oversight when establishing this partnership

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[102] NAIC. (2006). Long Term Care Partnership Provisions of Deficit Reduction Act of 2005. Retrieved April 3, 2007 from http://www.naic.org/documents/committees_b_ltcwg_sum_pship_prov.doc Congressional Research Service. (2005). Medicaid's long-term care insurance partnership program.

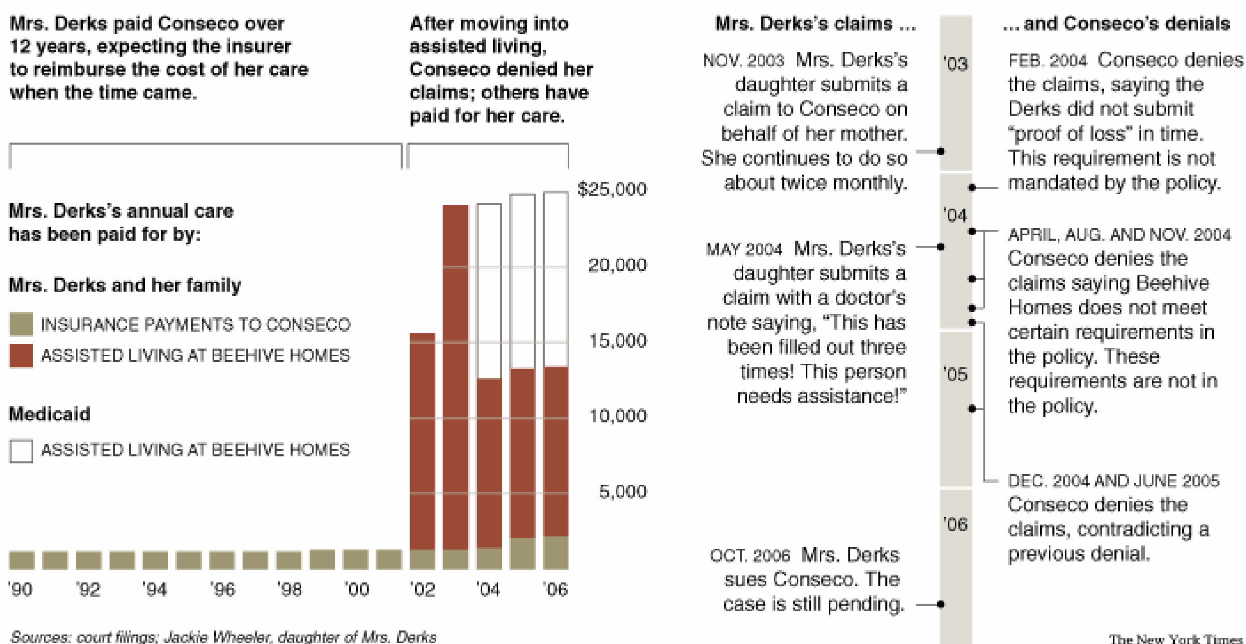
[103] Congressional Research Service. (2005). Medicaid's long-term care insurance partnership program.

[104] NAIC. (2006).

with private insurers. Figure 3 below features Mrs. Derks' experiences with her long-term care insurance provider, from the time of purchase through repeated denials of her claims. She purchased the policy at age 65 to avoid being a financial burden on her family should she require long-term care services in the future.

When that time arrived, however, her first claim to move to an assisted living facility was denied, starting a four-year long string of denials that have resulted in her family paying $70,000 and spending countless hours contesting the company's decision. Meanwhile, due to the continuous denials, Mrs. Derks' eventually received coverage, not by her private insurer Conseco, but by Medicaid—a result which having a private long-term care insurance policy was supposed to avert.[105] Mrs. Derks' experience has been echoed by thousands of other policyholders. For example, one in every four long-term care claims filed were denied by California long-term care insurers.[106]

Figure 3: Mary Rose Derks' experience with Conseco, her long-term care insurance provider



Oversight of partnership programs should cover claims processing procedures, so that Mrs. Derks' story does not become the common experience of policyholders. Additionally, regulation and oversight involves the protection of the consumer against unnecessary premium increases. Premiums are supposed to remain fixed at the rate set at the time of purchase, unless the state insurance commissioner approves a rate increase for all policyholders within a particular classification.[107] While this theoretically can protect the consumer from unjustified rate

[105] Duhigg, C. (2007). Aged, frail, and denied care by their insurers. *New York Times*, March 26, 2007.
[106] Duhigg, C.
[107] Stone-Axelrad, J.

increases, it can also result in carriers setting initial premium levels artificially high to avoid the hassle and risk of seeking state approval for the rate increase later.[108]

Overall, in implementing a public-private partnership, it is important to remember that private industry has certain financial goals to preserve and is not necessarily willing to voluntarily offer coverage to high-risk (i.e. potentially very expensive) policyholders out of a sense of altruistic virtue.

If the partnership programs are to truly save Medicaid money in the future, high-risk persons need to be able to purchase policies, maintain payments on these policies, and receive benefits from the policies purchased.

If the partnership programs are to save Medicaid money in the future, high-risk persons need to be able to purchase policies, maintain payments on these policies, and receive benefits from the policies purchased. Due to the collaborative nature of these partnership programs, the state has an opportunity to ensure that policyholders can purchase a quality product that will not abandon them in their time of need. As far as partnership policies are concerned, three pilot states require that all partnership policies meet a specific standard, which means that long-term care insurance policies that qualify for partnership program status have met a standard of quality that can provide some security to the purchaser. [109]

Implications and Recommendations for Missouri

To further protect Missouri consumers of long-term care insurance partnership programs, the task force recommends consideration of the following suggestions:

- Establishing an oversight committee and a consumer advisory board to ensure that qualified insurers fulfill their contractual obligations to their policyholders fully;
    - Granting this oversight committee the power to regulate rate increases;

- Including a sunset provision for the partnership program, so that if it is proven ineffective in terms of increasing coverage for Missouri citizens' long-term care services it may lapse;

- Designing and implementing a thorough evaluation plan, complete with feasible, measurable goals that can be accomplished by the sunset date, to inform the Department of Insurance and the Missouri State Legislature about the progress of the partnership program;

- Including specific standards for policies and carriers to meet in order to be considered qualified under the partnership program;
    - Including non-forfeiture language in these standards;
    - Including consumer inflation protection and fair rate setting provisions;

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[108] Stone-Axelrad, J.
[109] Stone,-Axelrad, J

- Allowing policyholders to receive reciprocity between other states with partnership programs, so that they may retain their assets while qualifying for Medicaid, should they choose to move to another state;
- Adopting all of the National Association of Insurance Commissioners standards for model long-term care insurance policies;

- Implementing a comprehensive education and outreach plan that includes consumer education and counseling, as well as training for qualified insurance providers;

- Including specific language guaranteeing benefits and asset protection for partnership policyholders, if the program sunsets.

Section 9: Recommendation & Supplemental Options in Light of Current Legislation

Summary of Recommendations and Improvements

The task force recommends implementation of the partnership program because some consumers stand to benefit from its establishment. Given that the State's Department of Insurance must certify that the long-term care insurance policy has met certain standards, the purchaser can be assured that qualified policies contain standard provisions established to protect the consumer. Also, receiving long-term care through a private insurance policy provides additional assurance that the policyholder can access long-term care services in the least restrictive environment. Privately-paid long-term care gives the consumer greater control over the care he/she will receive. Greater access to long-term care insurance, therefore, has the ability to empower more of Missouri's citizens to direct their long-term care services.

Additionally, the task force thinks it is essential to offer consumers comprehensive education about long-term care services and guidance through the purchasing process, in order to assist consumers in making informed decisions about the services they need covered and the various consumer protections that are available to them. The task force recommends the following quality measures to help consumers make educated decisions and to protect consumers within the long-term care insurance market:

- Closely monitor the denial rates and reasons for denial within the proposed LTCI partnership program;
- Establish an independent review board that reviews denied claims to ensure that underwriting process maintains ethical standards within the partnership program;
- Implement a consumer hotline to assist partnership program applicants;
- Provide education on the applicants' right to appeal denial decisions and reapply to different insurance companies within the partnership program.

The task force has also determined that Missouri can realize cost-savings from implementing the long-term care insurance partnership program, but this can only be done with appropriate targeting of purchasers. Policies must be made affordable and attractive to purchasers in the middle- to lower-income bracket, precisely those who might not otherwise purchase long-term care insurance. This type of targeting can be achieved with the state's help through offering tax deductions and credits, premium assistance, and subsidies. Even with these incentives in place and if proper targeting is successful, savings will take anywhere from 10 to 20 years to emerge. To help with targeting, the task force recommends that the state of Missouri provide incentives for purchasing long-term care insurance policies by exploring the following options:

- Providing deductions through cafeteria plans and flexible spending accounts through employers;
- Allowing premium payments without penalty from IRA, 401(k), and similar tax-deferred retirement accounts;
- Offering a tax credit in addition to the tax deduction; the tax credit would provide a greater benefit to those with lower incomes.[110]

[110] CFD.

- Subsidizing the purchase of long-term care insurance policies through offering means-tested individuals premium assistance through subsidies paid directly to the provider.

In addition to ensuring the quality of insurance policies offered and making these policies more accessible financially, the task force recommends Missouri consider the following suggestions as additional consumer protections to hold the insurance industry accountable.

- Establishing an oversight committee and a consumer advisory board to ensure that qualified insurers fulfill their contractual obligations to their policyholders fully;
  - Granting this oversight committee the power to regulate rate increases;

- Including a sunset provision for the partnership program, so that if it is proven ineffective in terms of increasing coverage for Missouri citizens' long-term care services it may lapse;

- Designing and implementing a thorough evaluation plan, complete with feasible, measurable goals that can be accomplished by the sunset date, to inform the Department of Insurance and the Missouri State Legislature about the progress of the partnership program;

- Including specific standards for policies and carriers to meet in order to be considered qualified under the partnership program;
  - Including non-forfeiture language in these standards;
  - Including consumer inflation protection and fair rate setting provisions;
  - Allowing policyholders to receive reciprocity between other states with partnership programs, so that they may retain their assets while qualifying for Medicaid, should they choose to move to another state;
  - Adopting all of the National Association of Insurance Commissioners standards for model long-term care insurance policies.

- Implementing a comprehensive education and outreach plan that includes consumer education and counseling, as well as training for qualified insurance providers;

- Including specific language guaranteeing benefits and asset protection for partnership policyholders, if the program sunsets.

Feasible Supplemental Options to Consider

While the task force supports the establishment of the long-term care insurance partnership program in Missouri, the findings of this report indicate that it will take careful implementation and the passage of time for Missouri to fully realize any financial benefit from the program's implementation. Two feasible supplemental options currently exist within Missouri, however, that are already resulting in cost-savings to Missouri's Medicaid spending. Expansion of access and use of these programs has the potential to reduce Missouri's Medicaid spending and produce more immediate financial benefit than the partnership program. Used in conjunction with the partnership program, the state of Missouri stands to realize significant savings across various segments of its population. These programs are the Home and Community Based Services

(HCBS) Waivers and the Programs for All-Inclusive Care for the Elderly (PACE). More detailed descriptions of both programs follow.

Increased Access to Home and Community Based Services (HCBS) Waivers

Missouri should examine the savings generated through its HCBS waiver programs and consider further development of waiver programs geared towards aging in place versus continued reliance on traditional institutional care, which is often more expensive. When compared to the savings generated through the partnership programs, HCBS waivers have out-preformed the existing partnership programs in producing Medicaid Insurance savings. Reports from Colorado, Oregon, and Washington reveal a savings of more than $139.9 million over the course of one year through the use of HCBS waivers.[111] Based on these early, yet limited, finding, HCBS waivers are a valuable and cost-effective supplement to a long-term care insurance partnership program.

One way to examine the savings generated through HCBS waivers in Missouri is to compare the cost-savings associated with waivers versus nursing home placements. In 2005, 24,703 individuals were receiving services under the HCBS waiver for the aged/disabled, with an average yearly cost of $9,846 and a combined total of over $243 million. These services were provided in the home and community versus the alternative nursing home setting. Had the 24,703 individuals been served in a nursing home, with an average yearly cost of $24,000, Medicaid Insurance would have incurred a combined total expenditure exceeding $592 million.[112] The resulting impact of HCBS waivers for 24,703 individuals receiving services in the home and community has saved Medicaid $349 million.

This cost-savings far outweighs the cost-savings for the foreseeable future of the LTCI partnership program. The waiver program also ensures that people with pre-existing conditions and disabilities, who would most likely be denied acceptance for partnership policies, have equal access to long-term care services in the least restrictive environment that promotes greater independence and results in cost-savings to Medicaid Insurance.

Increased Utilization of PACE Model

Programs for All-Inclusive Care for the Elderly (PACE) have been shown to promote independent living in the home and community, reduce hospitalization rates, and reduce early, often avoidable nursing home admissions.[113] PACE utilizes a capitated payment model where the provider assumes the cost of care for participants as a set monthly rate. Under this model, PACE has been shown to decrease state's Medicaid spending by 5 to 10% each year, as compared to the fee-for-service of institutional care.[114] Based on this data, the Missouri PACE program potentially saved $40 to 80 million in Missouri Medicaid spending. Decreasing the

[111] Grabowski C. D. (2005). The cost-effectiveness of non-institutional long-term care services: Review and synthesis of most recent evidence. Medical Care Research and Review. 63 (1), 3-28.
[112] Missouri Medicaid basics.
[113] Grabowski C. D.
[114] Chu, Y.K.G. (2001). Comprehensive care for the elderly: Is PACE the answer? Harvard Health Policy Review, 2 (1).

hospitalization and early nursing home admissions alone is seen as a cost-savings to Medicaid Insurance. The Task Force recommends that Missouri increase its utilization of HCBS waivers and the PACE model in an effort to reduce costs and increase the quality outcomes of individuals with Medicaid Insurance.

Section 10: Conclusion

Two key questions are addressed through this Task Force report. First, the Task Force examined the following:

- **Would a long-term care insurance program reduce Missouri's expenditures on long-term care in the Medicaid Program?**

Long-term care insurance partnership programs are one of many innovations devised to address the cost of long-term care. As the partnership programs have been implemented to date, they assist a specialized segment of the nation's population and would likely serve a specialized segment of Missouri's population, once implemented. The Task Force research finds that tax deductions target individuals with higher income and asset levels, who are less likely to spend down assets and become eligible for Medicaid Insurance during their life time. If the majority of individuals purchasing partnership programs never qualify for Medicaid Insurance based on income and asset levels; then, in effect, tax deductions targeted at the wrong population will do little to decrease the overall spending results of Medicaid Insurance.

A tax credit would potentially serve over 12,000 current long-term care Medicaid Insurance recipients with a potential savings to Medicaid Insurance of $210.6 million a year.

As explained earlier, estimates predict a 6.8% savings to Medicaid expenditures by 2020, assuming Missouri is able to effectively target over 7,458 people who are at risk for early asset spend down and Medicaid reliance for long-term care services. This would amount to a savings of over $144 million.

To reach this level of savings, the Task Force recommends that Missouri implement a Tax Credit targeted at lower-income and older Missourians who are most at risk for early asset spend down and reliance on Medicaid Insurance for long-term care services. To date, only 13.6% of all partnership policies have been purchased by individuals with assets below $100,000.[115]

Effectively reducing the cost of Medicaid Insurance depends on increasing the amount of policy purchases made by middle- and lower-income individuals with lower assets. The Task Force found that a Tax Credit would improve the market penetration of low-income and older adults to 16.5%, and reduce the lapse rate to an average of 5.5%. In light of current long-term care Medicaid Insurance spending, a tax credit would potentially serve over 12,000 current long-term care Medicaid Insurance recipients with a potential savings to Medicaid Insurance of $210.6 million a year.

While those served by the partnership program policies will enjoy more standardized policies, consumer protections, and asset protection, many of Missouri's citizens will be left out, unless the state enacts certain provisions to support the purchase of long-term care partnership policies within the middle- and lower-income brackets. These provisions, primarily based in the tax

[115] Axelrad, J. (2005).

structure but also including direct subsidies, are the key to unlocking the greatest cost-savings for the state from the partnership program.

Finally, the Task Force answered the following question:

- **Are there other equal or more feasible options Missouri should consider implementing?**

Not only did this Task Force find feasible alternatives, but also effective alternatives aimed at reducing Medicaid Insurance expenditures. The HCBS waiver and Missouri PACE model combined currently save the state of Missouri an estimated $389 to 429 million in Medicaid Insurance savings per year. Realizing that the average denial rate for LTCI Partnership programs is 16%[116], it is important to recognize that Medicaid Insurance will continue to play an important role in meeting the long-term care needs of those Missourians with chronic illness and disabilities that preclude their participation in the LTCI partnership program.

While the task force supports the implementation of the partnership program, it is with the caveat that a more comprehensive focus is needed in addressing the universal long-term care needs of the whole population. Expansion of existing programs that support home and community-based, non-institutionalized care is yet another step towards building a more comprehensive long-term care system. An ideal long-term care system incorporates these programs, and others that have yet to be developed, in order to equitably and efficiently serve all who require long-term care services – with the widest array of services in the least restrictive environment available. The task force believes that the partnership program and expansion of the feasible options discussed within this report are important steps towards building this ideal long-term care system for Missouri, so that Missourians throughout the state can receive the quality and type of care they need in the setting they choose.

[116] Alliance for Health Reform (2007).

Section 11: Appendix

Appendix A. Comparison of pilot states.

State	Covered benefits	Length of coverage	Elimination period	Non-forfeiture	Inflation protection	Policy type
CA- as of 12/03	% of policies with comprehensive benefits: 94% % of people with nursing home only: 6%	1~3 yrs: 36% 3~5 yrs: 33% 5 yrs: 4% Lifetime: 27%	(data from quarter ending 12/03) 90 days: 72% 60 days: 1% 30 days: 27% 0~15 days:<1%	Required	5% annual compound inflation adjustment required for age 70 and under: compare may offer a 5% annual: simple adjustment to applicants over age 70	100% individual products
CT- as of 12/03	% of policies with nursing home and home care: 99% % of policies with nursing home only: 1%	1~2 yrs: 20% 2~4 yrs: 47% 5+ yrs: 8% Lifetime: 16%	Days / Nursing home / Home care 90 / 43% / 40% 60 / 8% / 8% 0 / 1% / 23% Other / 48% / 29%	99% had no non-forfeiture protection	100% of policies include one of three state-defined options for inflation protection	Individual: 83% Group: 17% (cumulative)
IN- as of 3/04	% of policies with comprehensive benefits: 86% % of policies with nursing home only: 14%	1~3 yrs: 6% 3~5 yrs: 14% 5+ yrs: 69% Lifetime: 11%	**For nursing home:** 90+ days: 59% 30 days: 20% Other: 21% **For home and community-based care:** 90+ days: 35% 30 days: 18% 0 days: 38% Other: 9%	99% had no non-forfeiture protection	5% annual compound inflation required	Individual: 96% Group: 1% Organization-sponsored: 3%
NY- as of 9/03	Almost 100% of policies sold covered nursing home care and home care	Minimum of three years of nursing home coverage and/or six years of home care coverage required	100 days: 76% 30-99 days: 12% Up to 30 days: 14%	Shortened benefit period: 52% None: 48%	5% compound inflation required for under age 80 Age 80 and above: 77% purchased none and 24% purchased 5%	Individual: 90% Group: 5% Organization-sponsored: 5%

Sources: Data provided to CRS by partnership states.
Note: Comprehensive benefits – includes coverage of nursing home care and home care. Inflation protection – inflates the daily pay out amount and the total benefits
Key: NH=nursing home: HC=home care

Appendix B. Selected consumer advice on long-term care insurance.

Area of Advice	Suggestion	Other Considerations
At what age should you purchase Policy features	Age 40 and certainly by age 65. (Consumers Union)	
Daily benefit amount	Find out what long-term care costs in your area to help determine the base amount (AARP, NAIC)	Consumer need not buy insurance that covers the full cost of care since some long-term care is financed by Medicare (CMS)
Benefit trigger	Limits in two ADLs and that one of the ADLs used in the list should be a limitation in bathing (Consumers Union) Be sure that Alzheimer's disease is covered (NAIC/HIAA)	Eligibility should be certifiable by policyholder's physician rather than someone chosen by the insurance carrier (AARP) Don't buy a policy that requires hospitalization or nursing home care or skilled nursing care in order to begin receiving benefits (NAIC/HIAA; IMSA) Avoid policies that do not cover care received outside of the U.S. (LTCFEDS.COM)
Types of services	In-home care and nursing home care should be covered (AARP) Alternative care facilities, like care at an assisted living facility should be covered (ConsumersUnion) Personal care and homemaker services (i.e. cooking, shopping) should be an option (AHCA, NCAL, ElderLawAnswers.com)	Services covered should not be limited to skilled care (NAIC/HIAA) Home care benefit should include adult day care, hospice services, and respite care. (Consumers Union)
Waiting periods (sometimes called the elimination period or deductible)	30 days (Consumers Union)	Buy a policy in which this is applied once, rather than for each episode of care (AARP)
Length or duration of coverage	At least one year (NAIC/HIAA)	Four years (Consumers Union)
Inflation protection	Buyers should obtain a policy that automatically increases the benefit amount over time (AARP) For buyers age 70 or older, 5% annual increases should be sufficient and for younger buyers a compounded 5 percent benefit amount (NAIC Shopper's Guide)	A 65 to 75 year old should consider buying a 6-year or lifetime benefit with simple inflation. Those ages 75 and older should buy a bigger daily benefit for as long a period as they can afford (ElderLawAnswers.com)
Non-forfeiture of benefits, if you should stop paying premiums	Highly recommended (NYSUT)	It adds to the cost, but you should consider it (Consumers Union)
Waiver of premiums while receiving benefits	Yes (NYSUT)	Make sure there are no restrictions while receiving benefits (HIAA)
Other provisions	Find a policy that provides an ability to increase or decrease coverage (NYSUT)	The right to change the benefit should be guaranteed without providing evidence of insurability (NAIC/HIAA)
How much should you spend on long-	No more than 7 percent of annual income (United Seniors Health	If the premium is a concern, it is better to purchase a 2-year policy with inflation

Appendix B. Selected consumer advice on long-term care insurance.

Area of Advice	Suggestion	Other Considerations
term care insurance?	Cooperative) Not more than 5 to 10 percent of income (ElderLawAnswers.com)	protection than a longer term policy without inflation protection (medicare.gov) Check with your state's insurance department to learn how rate increases are regulated (NAIC Shopper's Guide)
Financial strength of insurer	Rated in one of the top two categories by at least two rating services, such as A.M. Best, Moody's Investor Services, Fitch Ratings, or Standard & Poor's) and have no low ratings (NYSUT)	Weiss financial safety rating of at least a B+ (Consumers Union)
Insurer reputation	Insurance company is a member of the Insurance Marketplace Standards Association	
Agent commission	Consumers should know how their agent is paid (Consumers Union)	Be sure the commission amount is within reason (NYSUT)

Source: ihcrp.georgetown.edu/agingsociety/pubhtml/choosingltci.html

Appendix C. Comparison of current (2007) legislation establishing the Missouri Long-term Partnership Act.

Area of Analysis	SB 577 (House Committee Substitute)	HB 40 (Perfected)
Tax Incentive	An increase from 50 to 100% tax deduction for all nonreimbursed premiums. (Premiums cannot also then be included in the individual's itemized deductions.)	An increase from 50 to 100% tax deduction for all nonreimbursed premiums. (Premiums cannot also then be included in the individual's itemized deductions.)
Asset Disregard	Disregard of any assets or resources in an amount equal to the insurance benefit payments that are used on behalf of an individual	Disregard of any assets or resources in an amount equal to the insurance benefit payments that are used on behalf of an individual
Protection against rate fixing	Two or more insurers issuing long-term care insurance shall not act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems.	Two or more insurers issuing long-term care insurance shall not act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems.
If the partnership program is discontinued…	An individual who purchased a qualified long-term care partnership approved policy prior to the date the program was discontinued shall be eligible to receive asset disregard.	An individual who purchased a qualified long-term care partnership approved policy prior to the date the program was discontinued shall be eligible to receive asset disregard.
Reciprocity between states	DSS may enter into reciprocal agreements with other states with asset disregard, the asset disregard will be extended to a Missouri residents who purchase long-term care policies in another state.	DSS may enter into reciprocal agreements with other states with asset disregard, the asset disregard will be extended to a Missouri residents who purchase long-term care policies in another state.
Professional registration	Ensures individuals selling qualified policies have received training and demonstrates an understanding of policies and how they relate to public and private coverage of long-term care.	Ensures individuals selling qualified policies have received training and demonstrates an understanding of policies and how they relate to public and private coverage of long-term care.
Policy Regulation	The Dept. of Insurance may impose no requirements affecting the terms or benefits of qualified long-term care partnership policies unless such requirements on all policies sold within the state.	The Dept. of Insurance may impose no requirements affecting the terms or benefits of qualified long-term care partnership policies unless such requirements on all policies sold within the state.
Consumer Services	The Dept. of Insurance provide clear language for the consumer pertaining to the asset disregard and asset tests.	The Dept. of Insurance provide clear language for the consumer pertaining to the asset disregard and asset tests.
Inflation Protection	Shall be no less favorable than that offered under NAIC's Long-term Care Insurance Model Act and Regulation.	---------

Area of Analysis	SB 577 (House Committee Substitute)	HB 40 (Perfected)
Evaluation	Issuers of policies shall provide regular reports to the secretary of DHHS.	Issuers of policies shall provide regular reports to the secretary of DHHS.
Consumer Replacement	An individual who exchanges non-qualified long-term care insurance for a qualified policy receives equitable treatment for time or value gained.	--------------
Certifying qualified policies	The director of the department of insurance, financial and professional regulation shall promulgate rules to carry out process for certifying qualified long-term care partnership policies. The general assembly can review, delay, disapprove, or annul a rule held unconstitutional.	The director of the department of insurance, financial and professional regulation shall promulgate rules to carry out process for certifying qualified long-term care partnership policies. The general assembly can review, delay, disapprove, or annul a rule held unconstitutional.
Sunset Provision	--------------------	Provisions shall sunset automatically six years after the effective date, unless reauthorized by an act of the general assembly. Furthermore, the program, if reauthorized, shall sunset automatically twelve years after the effective date of reauthorization.

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